Western Veterinary Clinic

25190 State Road 2 • South Bend, IN • 46619
Phone: (574) 234-3098 • Fax: (574) 287-3835 • Email: info@westernvet.com

U/S Date: _____

U/S Time: _____

Ultrasound Referral Request

Referring Veterinarian: _____ **Referring Veterinary Clinic:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Patient Information

Name: _____ **Species:** ❑ Dog ❑ Cat ❑ Other _____

Sex: ❑ Male ❑ Neutered ❑ Female ❑ Spayed **Breed:**_____ **Color:**_____ **Age:** _____

Will sedation be necessary? ❑ Yes ❑ No **Will client be present to view ultrasound?** ❑ Yes ❑ No

Owner Information

First Name:_____ **Last Name**:_____

Home Phone:_____ **Work/Cellular Phone**:_____ **Emergency Phone:** _____

Street Address: _____

City: _____ **State:** _____ **County:**_____ **Zip:**_____

Spouse/Alt Contact: _____ **Relation:**_____ **Phone:**_____

Current Problem

Differential Diagnosis: _____

History:

Diagnostics performed: ❑ X-rays ❑ Blood Work ❑ EKG ❑ Other _____
History & digital X-rays may be emailed to info@westernvet.com

Ultrasound Study Requested

❑ Abdominal: Areas of interest: _____
❑ Cardiac: Please send lateral and VD thoracic radiographs
❑ Thoracic (non-cardiac): Please send lateral and VD thoracic radiographs
❑ FNA/Biopsy: Organ(s) to be biopsied: _____
Please submit results of blood work and coagulation panel for all biopsies
❑ Check if you would like a copy of the ultrasound study sent to you on a CD-ROM

Please tell the client the following:

- For abdominal U/S, except for diabetic pets, please do not feed for 8 hours prior to appointment time if possible. Water is OK.
- Continue regular medications
- Do not allow your pet to urinate for at least one hour before the ultrasound, if possible.
- Payment is due when services rendered. We accept cash, debit, credit card, CareCredit, and check.