THE ONCOLOGY SERVICE

Outpatient CT Referral Form

TOS - SPRINGFIELD | 703-451-8900 | 6651 Backlick Road

Please complete the following and send with related records (recent records and labwork). Once we receive the information we will call the owner to schedule an appointment. **Please submit to: Fax: 703-783-6318 or Email: TOSSpringfield@ethosvet.com.**

CLIENT INFORMATION: (please fill out on behalf of the client)

Client Name: ____________________ Phone: ____________________

Patient Name: ____________________ DOB: ____________________

Breed: ____________________ Species : ◯ Canine ◯ Feline

Sex: ◯ Neutered Male ◯ Spayed Female ◯ Intact Male ◯ Intact Female

Weight (kg): ____________________

REFERRING VETERINARIAN INFORMATION:

Referring Veterinarian: ____________________

Hospital/Service: ____________________

Phone: ____________________ Fax: ____________________ Email: ____________________

Contact Person for Day of Appointment: ____________________

PERTINENT MEDICAL HISTORY:

For us to provide your patient with the best care possible, please indicate all medical problems, current medications, and history of anesthetic complications or drug sensitivities. Attach any necessary paperwork to complete this request.

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CT STUDY: (please check all that apply)

Head/Neck		Limb/Joints L	R		Spine		Soft Tissue	
	Nasal Cavity/Sinuses			Carpus/metacarpals		C1 - T2		Neck
	Osseous bullae			Radius/ulna		T3 - L3		Thoracic
	Orbits			Elbow		L4 - Sac		Abdomen
	Maxilla/Mandible (Dental Arcade)			Humerus		Other:		Pelvis
	Pharynx/Larynx			Shoulder				Pulmonary met check (No Contrast)
	Skull			Hips				
	Brain			Pelvis				
				Femur				
				Stifle				
				Tibia/Fibula				
				Tarsus/Meta Tarsals				
Contrast included unless otherwise specified				Other:	Contrast:		Contrast included unless otherwise specified	
						Y		
		Contrast: Y: N:				N		

◯ Include set-up for potential radiation (an additional charge). Please note any special requests as previously discussed with the attending TOS clinician (i.e. positioning, procedures) ____________________

Referring Veterinarian Signature: ____________________ Date: ____________________

THE ONCOLOGY SERVICE

Outpatient CT Referral Form

TOS - RICHMOND | 804-999-0001 | 5711 Staples Mill Road, Suite 102

Please complete the following and send with related records (recent records and labwork). Once we receive the information we will call the owner to schedule an appointment. **Please submit to: Fax: 804-482-2763 or Email: tosrichmond@ethosvet.com.**

CLIENT INFORMATION: (please fill out on behalf of the client)

Client Name: ______________________ Phone: ______________

Patient Name: ______________________ DOB: ______________

Breed: ______________ Species : ◯ Canine ◯ Feline Sex: ◯ Neutered Male ◯ Spayed Female ◯ Intact Male ◯ Intact Female

Weight (kg): ______________

REFERRING VETERINARIAN INFORMATION:

Referring Veterinarian: ______________________

Hospital/Service: ______________________

Phone: ______________ Fax: ______________ Email: ______________

Contact Person for Day of Appointment: ______________________

PERTINENT MEDICAL HISTORY:

For us to provide your patient with the best care possible, please indicate all medical problems, current medications, and history of anesthetic complications or drug sensitivities. Attach any necessary paperwork to complete this request.

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CT STUDY: (please check all that apply)

	Head/Neck	L	R	Limb/Joints		Spine		Soft Tissue
	Nasal Cavity/Sinuses			Carpus/metacarpals		C1 - T2		Neck
	Osseous bullae			Radius/ulna		T3 - L3		Thoracic
	Orbits			Elbow		L4 - Sac		Abdomen
	Maxilla/Mandible (Dental Arcade)			Humerus		Other:		Pelvis
	Pharynx/Larynx			Shoulder				Pulmonary met check (No Contrast)
	Skull			Hips				
	Brain			Pelvis				
				Femur				
				Stifle				
				Tibia/Fibula				
				Tarsus/Meta Tarsals				
	Contrast included unless otherwise specified			Other:		Contrast:		Contrast included unless otherwise specified
						Y		
				Contrast: Y: N:		N		

◯ Include set-up for potential radiation (an additional charge). Please note any special requests as previously discussed with the attending TOS clinician (i.e. positioning, procedures) ______________________

Referring Veterinarian Signature: ______________________ Date: ______________