



# Oakridge

VETERINARY IMAGING PLLC



## Small Animal Referral Form

6675 E. Waterloo Rd.  
Edmond, OK 73034

(405) 341-9350  
Fax: (405) 359-2869

Referral Hospital: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Hospital Phone: \_\_\_\_\_ Hospital Fax: \_\_\_\_\_

OWNER NAME: \_\_\_\_\_ Client Phone: \_\_\_\_\_

Client Address: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Canine  Feline  Other: \_\_\_\_\_

Male  Female  Spayed/Neutered?

Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Aggressive? Yes  No

**SPECIFIC AREA TO BE EVALUATED:** \_\_\_\_\_

History/Clinical Signs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preliminary Diagnosis: \_\_\_\_\_

All Current Medications: \_\_\_\_\_

Please include copies of any recent sedation/anesthetic events along with current bloodwork.

Has this patient ever had an adverse drug reaction? Yes  No

If yes, please attach an explanation.

Special Care Instructions: \_\_\_\_\_

Permission for General Anesthesia? Yes  No

Are we authorized to perform resuscitation measures if required? Yes  No

Does this patient require special anesthetic considerations? Yes  No

Would you like a copy of the MR images on a CD? Yes  No

REFERRAL POLICY: Patients referred by veterinarians will receive services related to the presenting problem only. Clients are requested to return to their referring veterinarian for all other services.

PERMISSION TO SCAN is granted by the signer below as representative of the referring hospital, or as the patient's owner.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_