



The Hope Center
 140 Park Street, SE
 Vienna, VA 22180
 PHONE 703.242.4747
 FAX 703.880.7566

CT Referral Form

Please complete the following and fax together with all necessary paperwork to your local imaging center.

General Information

- It is very important to note that your patient will be anesthetized for the CT. Please advise your clients as to the risks of anesthesia as well as any special instructions regarding medications to be given before the CT.
- We are not equipped to handle laboratory testing or imaging other than CT. Therefore, all required testing must be completed by you and results furnished prior to our anesthetizing your patient. A list of required tests has been provided. Do not hesitate to contact us should you have any specific questions.
- As we are an outpatient facility only, patients must be stabilized before we can proceed with a CT.

Referring Veterinarian Information

Clinic Name _____ **Bill to: Client / Clinic**

Veterinarian #1 _____ Veterinarian #2 _____

Address _____ City _____ State _____ Zip _____

Clinic Number _____ Fax Number _____

Client and Patient Information

Client's Name _____ Phone Number _____

Street Address _____ Alt. Phone # _____

City/State/Zip _____ Species _____ Breed _____

Patient Name _____ Age _____ Weight _____ Sex _____ Color _____

Case History and Medical Information

Please indicate patient history including past and current medical problem(s), results of all diagnostic testing, any medication(s) prescribed, and response to medication(s), if any. Please include any sensitivity to anesthesia or any known allergies. Please feel free to attach additional patient history as necessary.

1. AREA TO BE IMAGED please check study of interest and circle L or R as required

| SPINE | BRAIN | HEAD/NECK | LIMB/JOINTS | SOFT TISSUE |
|--|--------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> Cervical (C1-T2) | <input type="checkbox"/> Brain | <input type="checkbox"/> Nasal Cavity/Sinus | <input type="checkbox"/> Stifle (L / R) | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Thoracic (T1-L1) | | <input type="checkbox"/> Osseous Bullae | <input type="checkbox"/> Elbow (L / R) | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Lumbar Spine (L1-S1) | | <input type="checkbox"/> Skull | <input type="checkbox"/> Hip (L / R) | <input type="checkbox"/> Chest Wall |
| <input type="checkbox"/> Thoracic/Lumbar (T8-S1) | | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Pelvis (L / R) | <input type="checkbox"/> Thorax |
| | | | <input type="checkbox"/> Shoulder (L / R) | |
| | | | <input type="checkbox"/> Limb Fracture | |
| | | | | (Specify) |

2. SPECIFIC SEQUENCES REQUESTED (please check):

Standard CT STAT Read Other (specify) _____

Signature of Veterinarian Requesting Test _____

Consent Form

Client Name: _____ **Patient Name:** _____

Species: Canine / Feline **Breed:** _____ **Sex:** _____

Consent Form - General Anesthesia and CT

CONSENT FOR GENERAL ANESTHESIA AND CT

As the owner of or agent for the owner of the above animal, I hereby give my consent to PetsDx Veterinary Imaging, The attending veterinarian, and the staff of PetsDx Veterinary Imaging to administer general anesthesia and perform a CT (Computed Tomography Imaging) on the above named animal. The nature and risks of the procedure have been explained to me and all of my concerns have been addressed.

I understand that general anesthesia is required for a CT and I also understand that a contrast agent may be used in the above named animal during the course of the CT scan. I understand that risks and potential complications do exist with anesthesia, CT scans, and the use of contrast agents. These risks and potential complications include, but are not limited to: Aspiration pneumonia, abnormal reaction to anesthetic or contrast agents causing anaphylaxis, organ failure (heart, liver, kidney), cardiac or respiratory arrest, and death. In the event that complications do occur, I authorize the attending veterinarian and the staff of PetsDx to administer all necessary treatments, including CPR (cardiopulmonary resuscitation) if needed. I also understand that the severity of the complications may warrant transfer back to the referring veterinarian or to the Emergency Service within The Hope Center veterinary hospital for more intensive care and I authorize the attending veterinarian to transfer the above named animal as necessary.

I acknowledge that no guarantees have been made except reasonable precautions against injury, escape, or illness with the understanding that I will remain fully responsible for the cost of all services provided by PetsDx Veterinary Imaging and its authorized agents.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND CONSENT

Signature of Owner or Agent _____

Date _____

EMERGENCY NUMBER _____

Consent Form