Valley Veterinary Hospital
Ultrasound Imaging - DVM Referral Form

- Please complete the following information.
- Email all medical records and diagnostic results to **staff@valleyvetoshkosh.com**
- We will contact the owner to schedule a consultation.

Referring Veterinarian:

Hospital Name:

Hospital Address:

Hospital Email:

Hospital Phone:

Client Name:

Client Address:

Client Email:

Client Phone:

Patient Name:_____Breed:_____

DOB:_____Color:_____Sex: M F Spayed/Neutered

Weight:_____Current on Vaccines: Yes No

Master Problems/Preexisting Conditions (Any conerns if injectable anesthetic needs to be used?):

Current Medications:

Tentative Diagnosis/Reason for Referral:

Patient History:

Reason for Imaging:

Expectations for this case:

□Abdominal Ultrasound - Reviewed by Boarded Radiologist
□Echocardiogram - Reviewed by Boarded Cardiologist
□Full Cardiac Work-up (3 view thoracic radiographs, ECG, echocardiogram) - Reviewed by Boarded Cardiologist

****Results will be emailed to the referring veterinarian within 1 week of completion; your team will need to consult with the client regarding findings/report.****
****Please provide oral sedation for referred patients if warranted to facilitate imaging****