

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 Sex: Neutered Male Spayed Female

 Weight (kg): _____ Feline Intact Male Intact Female

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.

CT STUDY: (please check all that apply)

Head/Neck		Limb/Joints		Spine	Soft Tissue			
		L	R					
<input type="checkbox"/>	Nasal Cavity/Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Carpus/metacarpals	<input type="checkbox"/>	Neck		
<input type="checkbox"/>	Osseous bullae	<input type="checkbox"/>	<input type="checkbox"/>	Radius/ulna	<input type="checkbox"/>	Thoracic		
<input type="checkbox"/>	Orbits	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Abdomen		
<input type="checkbox"/>	Maxilla/Mandible (Dental Arcade)	<input type="checkbox"/>	<input type="checkbox"/>	Humerus	<input type="checkbox"/>	Pelvis		
<input type="checkbox"/>	Pharynx/Larynx	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder		Pulmonary met check (No Contrast)		
<input type="checkbox"/>	Skull	<input type="checkbox"/>	<input type="checkbox"/>	Hips		<input type="checkbox"/>		
<input type="checkbox"/>	Brain	<input type="checkbox"/>	<input type="checkbox"/>	Pelvis				
<input type="checkbox"/>	Contrast included unless otherwise specified	<input type="checkbox"/>	<input type="checkbox"/>	Femur			Contrast: <input type="checkbox"/>	Contrast included unless otherwise specified
		<input type="checkbox"/>	<input type="checkbox"/>	Stifle				
		<input type="checkbox"/>	<input type="checkbox"/>	Tibia/Fibula				
		<input type="checkbox"/>	<input type="checkbox"/>	Tarsus/Meta Tarsals				
		<input type="checkbox"/>	<input type="checkbox"/>	Other:				
<input type="checkbox"/>	Contrast: Y: N:	<input type="checkbox"/>	<input type="checkbox"/>	Y	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: _____