



Canine Health Institute

3800 Southwest Freeway, Ste. 136
Houston, Texas 77027
713-341-9520 Voice ? 713 -341-9540 Fax
www.caninehealthinstitute.com

DIAGNOSTIC IMAGING REFERRAL FORM

Each patient should have a physical exam, CBC, chemistry panel (and thoracic radiographs if >6 years old) for the referring veterinarian to evaluate anesthetic risk prior to imaging. Anesthesia for a MR scan is approximately 1.5 to 2 hours. Send lab results and/or radiographs with this order if available.

Patient Name:	Age:	Gender:
Patient Weight:	Breed:	
Owner's Name:	Owner's Phone:	Cell Phone:
Owner's Address:		
Owner's City:	State:	Zip:
Referring Veterinarian:	Office Phone:	Office Fax:
Address:	Email:	

Please check the exam you are prescribing for this patient. Please only request one area. An additional area will result in an increase of 1-2 hours and higher fees.

Modality: Computed Tomography Magnetic Resonance Imaging

Spine	Brain	Head/Neck	Limb/Joints	Soft Tissue
<input type="checkbox"/> C1-T2	<input type="checkbox"/> Brain	<input type="checkbox"/> Nasal Cavity	<input type="checkbox"/> Brachial Plexus <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Abdomen
<input type="checkbox"/> T3-L3	<input type="checkbox"/> Brain + C1, C2 Spine	<input type="checkbox"/> Osseous Bullae	<input type="checkbox"/> Lumbosacral plexus	<input type="checkbox"/> Chest wall
<input type="checkbox"/> L4-Sacrum		<input type="checkbox"/> Orbits	<input type="checkbox"/> Stifle <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Mediastinum
<input type="checkbox"/> T3-Sacrum		<input type="checkbox"/> Sinuses	<input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Other:
<input type="checkbox"/> C1-Sacrum		<input type="checkbox"/> TMJ	<input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R	
<input type="checkbox"/> Other:		<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Pelvis	
		<input type="checkbox"/> Mandible	<input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R	
		<input type="checkbox"/> Other:	<input type="checkbox"/> Carpus <input type="checkbox"/> L <input type="checkbox"/> R	

Reason for Imaging Study (including presumptive diagnosis/differentials):

Does the patient have or has the patient had any of the following (if YES, please provide details):

<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Pacemaker	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Brain Surgery	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunts/Stents/Filters/Intravascular Coil	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Pins/Screws/Rods/Joints/Prosthesis	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Cancer or Tumors	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation or Chemotherapy	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous Cervical/Thoracic/Lumbar Surgery	When? _____ Implants placed? Y N Levels: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gunshot Wounds/ BBs	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the pet microchipped?	When? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingestion of any metal object	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Screening Radiographs for embedded metal	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Problems	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic Problems	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Problems	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Complete Blood Chemistry	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Biochemical Profile	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous anesthetic complications	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Reactions	_____

List previous surgeries:

I attest that the above information is accurate to the best of my knowledge.

Referring Veterinarian's Signature

Date



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