

OUTPATIENT ULTRASOUND REQUEST FORM

Date _____



Requesting hospital _____ Clinician _____

Client name _____

Patient name _____ Pet's DOB _____ Breed _____

Canine Feline Other: _____ Female Male Spayed Neutered

Pertinent history _____

Pertinent physical and laboratory findings _____

Tentative diagnosis _____

Ultrasound

Thorax Dual cavity
Abdomen Cervical, MSK/Superficial

Previous radiographs taken? Yes (Please send to us for supplemental information) No

Does pet have any known adverse drug reactions in case of need for sedation? _____

Do you expect FNA? Yes (Please provide recent bloodwork) No **Please note:** Biopsy procedures are not performed on an outpatient basis.

Specific questions you would like answered, or other comments _____

Fax or email completed form to:
253.474.6057 • info.tacoma@bluepearlvet.com
Please call our hospital if you have any questions.