Diagnostic Imaging Outpatient Ultrasound Referral Form

BluePearl Pet Hospital

BluePearlVet.com

Today's date _____

Please complete this form and send to **info.pitt@bluepearlvet.com** or fax to **412.366.3489**.

Referral partner information

Referring veterinarian _____

Referring practice _____

Phone _____ **Secondary phone** _____

What is your final report communication preference?

☐ Email _____

☐ Fax _____

PLEASE NOTE: Upon completion of the ultrasound exam, a report will be generated and sent to the referring veterinarian within 24 hours via the communication preference noted and through the portal system.

Patient and client information

Pet's name _____ **Pet's age** _____

Type ☐ Canine ☐ Feline **Breed** _____

Sex ☐ Male ☐ Male neutered ☐ Female ☐ Female spayed

Client's name _____

Phone _____ **Email** _____

Address _____

Sedation

All patients are to be sedated for the ultrasound exam unless other co-morbidities exist that could result in compromise to the patient. Please let us know your recommendation of the type of sedation based on the available sedation listed below:

Any adverse reactions to specific drugs? ☐ Yes ☐ No If yes, please list _____

Please choose a first drug.

☐ Alfaxalone ☐ Butorphanol ☐ Dexmetatomidine/Atipamezole reversal ☐ Diazapam

Prescribed dose _____ ☐ Mg/kg ☐ Mcg/kg

Please choose a second drug in combination to the first drug if needed.

☐ Alfaxalone ☐ Butorphanol ☐ Dexmetatomidine/Atipamezole reversal ☐ Diazapam ☐ A second drug is not needed.

Prescribed dose _____ ☐ Mg/kg ☐ Mcg/kg

See reverse side →

BluePearl Pittsburgh North
807 Camp Horne Rd.
Pittsburgh, PA 15237
412.366.3400

BluePearl Pittsburgh South
1535 Washington Rd.
Washington, PA 15301
724.809.2000

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Study information

(Any diagnostics performed (i.e., bloodwork or previous radiology reports) please attach or send in with this form for our records.)

Study type ☐ Abdomen

Reason for referral, primary complaint or comorbidities _____

_____

Clinical exam, pertinent abnormal labwork findings or working diagnosis _____

_____

Specific question to be addressed _____

_____

Cystocentesis ☐ Yes ☐ No

FNA approved ☐ Yes ☐ No If yes, were coags performed? ☐ Yes, normal ☐ Yes, prolonged ☐ No

Radiographs submitted (not to be read out) ☐ Yes ☐ No

Digital ☐ Sent to our DICOM server

Analog ☐ Sent with owner

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