ULTRASOUND REFERRAL FORM

Please have the referring vet fill up the form and send it by email to (frontdesk@bovc.ae) prior to the appointment date/time.

CLINIC INFORMATION	PATIENT INFORMATION
Referring Clinic:	Patient Name:
Phone:	Species:
Email:	Breed :
Fax:	Sex:
Referring Veterinarian:	Date of Birth:
Direct Contact:	Weight:

APPOINTMENT INFORMATION

Appointment is on Date: Time:	The patient will come with ☐ Owner ☐ Clinic Employee ☐ Other :
Documents:	
X-rays:	

Reason for referral:	
Region that shall be scanned: ☐ Urinary bladder and ☐ Kidneys ☐ Pregnancy ☐ Abdomen ☐ Thorax ☐ Echocardiography ☐ Others:	Current medication: Did this patient have any side - adverse effects on anaesthetics in the past? ☐ Yes ☐ No If yes, please provide details:
Special Requests:	

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