



X-RAY 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

Referring Clinic:
Phone:
Email:
Fax:
Referring Veterinarian:
Direct Contact:

PATIENT INFORMATION

Patient Name:
Species:
Breed :
Sex:
Date of Birth:
Weight:

APPOINTMENT INFORMATION

Appointment is on Date: Time:	The patient will come with <input type="checkbox"/> Owner <input type="checkbox"/> Clinic Employee <input type="checkbox"/> Other :
Documents:	
X-rays:	

Reason for referral:	
Region that shall be scanned:	Current medication: Did this patient have any side - adverse effects on anaesthetics in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details:
Special Requests:	