THE CITY VET CLINIC
ذا سيتي فيت كلينك

ULTRASOUND REFERRAL FORM

- Please send the completed form to alwasl@thecityvetclinic.com
- Please send the referral form together with the **MEDICAL HISTORY** of the patient
- Please send prior to the appointment date/time
- **IF THIS IS AN URGENT REQUEST**, please call 04-3883990 directly

Kindly fill out the form in PRINT

Referring Clinic Information			
Clinic Name		Date	
Referring Veterinarian			
Clinic Email			
Clinic Phone			

Client & Patient Information			
Client Name		Contact	
Client Email			

Patient Name		Species	
Breed		Sex	
Date of Birth		Weight	

Appointment Request			
Requested Provider - Specialist Name			
Appointment Date		Time	
The patient will come with	□ Referring Clinic Employee	□ Owner	□ Other

Procedure Information		
Ultrasound Request	□ Cardiac Ultrasound	□ Abdominal Ultrasound
Different Procedure Request, please specify:		
Reason for Referral (Symptoms/Tentative Diagnosis):		

Current Medication(s):

Special Request for the Specialist (if there is any):

***IMPORTANT*: Turnaround time for the full report is 3-5 working days. For immediate request, additional payment will be incurred. Please contact the reception team for further information.**