



Advanced Animal Imaging Referral Form

5902 Homestead Rd.
Fort Wayne, IN. 46814
Phone: (260) 434-1555
Fax: (260) 434-1557
www.advancedanimalimaging.com



Owner's Information

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Pet Insurance Company: _____

Referral Veterinarian

Doctor's Name: _____ Clinic Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Clinic Phone: _____
Fax: _____ Email: _____

Pet Information

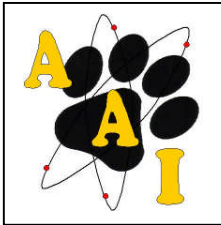
Name of Animal: _____ Species: _____ Breed: _____
Color: _____ Sex: _____ Date of Birth: _____ Weight: _____

Please Provide Dates

Dog	Cat
DHLPP _____ R _____ Bordetella _____	FVR-C-P _____ R _____ FELV _____
Heartworm Check: _____	FELV Test: _____
Preventative Dates: _____	Fecal: _____ Worming: _____
Fecal: _____ Last Worming: _____	_____
_____	_____

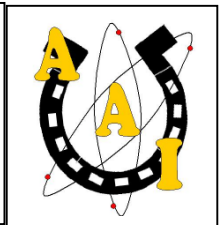
History and Pertinent Clinical Complaints

Diet: _____
Unusual Medical History (Allergies, Endocrine, Surgery) _____
Any Medications Currently Being Given: _____
If so, what dose: _____ Interval: _____



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Scheduled Appointment Date: _____ **Time:** _____

Service Requested:

- Digital X-Rays MRI Nuclear Medicine (Other)
 Ultrasound Nuclear Medicine Radioiodine I-131 Therapy
 OFA (Orthopedic Foundation for Canine Hypothyroid Testing)

The Report Should Be:

- Faxed to the Clinic Emailed to the Clinic The Clinic will view the report on the Website.

The Images Should Be:

- Sent with the Client Mailed to the Clinic The Clinic will view the images on the Website.

Exam Ordered:

<p>Digital X-ray</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Cervical Spine</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Extremity _____</p> <p><input type="checkbox"/> Lumbar Spine</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Thoracic Spine</p> <p><input type="checkbox"/> Skull</p> <p><input type="checkbox"/> Other _____</p>	<p>MRI [with (w) or without (w/o) contrast]</p> <p><input type="checkbox"/> Brain w/o</p> <p><input type="checkbox"/> Brain w & w/o</p> <p><input type="checkbox"/> Cervical Spine w/o</p> <p><input type="checkbox"/> Cervical Spine w & w/o</p> <p><input type="checkbox"/> Extremity _____</p> <p><input type="checkbox"/> Lumbar w/o</p> <p><input type="checkbox"/> Lumbar w & w/o</p> <p><input type="checkbox"/> Pelvis / Hip w/o</p> <p><input type="checkbox"/> Pelvis / Hip w & w/o</p> <p><input type="checkbox"/> Thoracic w/o</p> <p><input type="checkbox"/> Thoracic w & w/o</p> <p><input type="checkbox"/> Other _____</p>	<p>Ultrasound</p> <p><input type="checkbox"/> Abdomen (General) _____</p> <p><input type="checkbox"/> Adrenal Glands</p> <p><input type="checkbox"/> Bladder</p> <p><input type="checkbox"/> Chest Fluid Accumulation Evaluation</p> <p><input type="checkbox"/> Echocardiogram</p> <p><input type="checkbox"/> Eyes</p> <p><input type="checkbox"/> Kidneys</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Liver / Spleen / Pancreas</p> <p><input type="checkbox"/> Lymph Nodes _____</p> <p><input type="checkbox"/> Ovary / Uterus</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Stomach / Gastro-Intestinal</p> <p><input type="checkbox"/> Testicular / Prostate</p> <p><input type="checkbox"/> Tumor / Cyst _____</p> <p><input type="checkbox"/> Other _____</p>
<p>Nuclear Medicine Coming July 2010</p> <p><input type="checkbox"/> Radioiodine (I-131) Therapy (Alone)</p> <p><input type="checkbox"/> Feline (I-123) Hyperthyroid Evaluation</p> <p><input type="checkbox"/> Canine (I-123) Hypothyroid Evaluation</p> <p><input type="checkbox"/> Other _____</p>		
<p>Certain procedures may or will require sedation. For (abdominal ultrasound, stomach / gastro-intestinal ultrasound, liver/spleen/pancreas ultrasound, all MRI exams, I-131 therapy, I-123 exams) a prep is necessary – please call if you have any questions.</p>		

X _____ Date: _____

Signature of Referring Veterinarian



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Patient Preparation

Sedation / Anesthesia

For MRI and Ultrasound exams that may require sedation / anesthesia, a full CBC / Chem panel should be performed within 7 days prior to the exam. AAI can provide the needed lab work for a thorough sedation evaluation. If desired the client can bring the lab results or the facility can fax the result ahead of time to AAI. _____ CBC / Chem Panel

MRI

The pet shouldn't have any food or drink for 12 hours before the MRI examination. Please bring any pertinent lab work and x-rays with the client to the appointment.

Ultrasound

The pet shouldn't have any food or drink for 12 hours before an abdominal ultrasound. All other ultrasound exams have no prior preparations. Pet's that may need sedation should remain without food or drink for 12 hours prior to the examination.

Nuclear Medicine Thyroid Evaluation (Radioiodine I-131 Therapy, Hyperthyroid and Hypothyroid)

Please provide the following lab work, withhold the proper medications and follow the dietary restrictions. If the referring clinic is unable to obtain the requested labs, Advanced Animal Imaging can provide the needed lab work for a thorough evaluation.

Feline Hyperthyroid Evaluation and Therapy

Requested Referral Labs:

_____ Total T4 _____ Free T4 _____ BUN

_____ Serum Alkaline Phosphatase (ALP)

_____ Creatinine

Withhold the following medications for 7 days:

ACTH, Antocoagulants, Antihistamines, Bromides, Sutazolidine, Mercurials, Nitrates, Penicillin, Pentothal, Salicylates, Sulfonamidesm, Thiocyanate, Vitamins, Other Iodine Medications.

_____ BP

_____ Off of Tapazole for 7 days

_____ Chest X-ray

_____ Low Iodine Diet for 7 Days

_____ NPO (No food or Drink) 4 hours prior to the appointment.

Canine Hypothyroid Evaluation

Requested Referral Labs:

_____ T3 _____ T4 _____ TSH

_____ Thyroglobulin Autoantibodies (TgAA)

Withhold Thyroid Supplement for 3 months prior to testing.

_____ Low Iodine Diet for 7 Days

_____ NPO (No food or Drink) 4 hours prior to the appointment.

For OFA Canine Hypothyroid Testing please fill out the application forms.