VDIC

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REQUEST FORM

Requesting Veterinarian _____ **Date** _____
Requesting Hospital _____ VMS# _____
Address of Hospital _____ Tel. _____
City, State, Zip _____ FAX _____

PATIENT DESCRIPTION
Patient's Name_____ Owner's Name _____

ID #_____ Species_____ Breed_____ Sex _____ Age _____

RADIOLOGY **STAT** ☐

Thorax _____ Abdomen _____
Stifle _____ Tarsus _____
Skull _____ Spine _____
Shoulder _____ Elbow _____
Pelvis _____ Carpus _____
Foot _____

Other _____

ULTRASOUND

_____

CYTOPATHOLOGY **STAT** ☐

FNB/Imp. Smears_____ Location_____
Fluid Analysis _____
Peritoneal _____
Thoracic _____
Pericardial _____
Cerebrospinal _____
Synovial _____
Vaginal Smears _____
Urine Sediment _____
Blood Smear _____
Bone Marrow _____
Tracheal Wash _____
Other _____

Include location of lesion in history below

HISTORY, CHIEF COMPLAINT, CLINICAL FINDINGS

EMERGENCY REPORT (STAT) _____ (ADDITIONAL FEE)

COPY TO: _____ **FAX #:** _____