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REQUEST FORM

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

PATIENT DESCRIPTION

ID # _____ Species _____ Breed _____ Sex _____ Age _____
 Patient's Name _____ Owner's Name _____ T/P _____

RADIOLOGY

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

Other _____

ULTRASOUND

CYTOPATHOLOGY

FNB/Imp. Smears _____
 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 _____ (ADDITIONAL FEE)

RETURN X-RAYS NEXT DAY _____

COPY TO: _____ FAX #: _____