RADIOLOGY / CT / MRI / ULTRASOUND CONSULTATION REQUEST FORM
SUSQUEHANNA VETERINARY IMAGING, LLC

- Referring Doctor:
- Hospital Name and Address:

- Phone Number:
- Preferred Method of Contact:

  Phone (give number and best times to contact):

  E-mail (give address):

  Regular Mail

  Fax (give number):

- Owner's Name:
- Patient's Name:
- Breed: Sex: Age:
- Presenting complaint(s):

- Duration:
- Pertinent physical exam findings, laboratory results – especially abnormal values (use back if necessary):

- Provisional Diagnosis:

Thank you very much for your referral. You will be contacted within 24 hours with a report.

Van W. Knox IV, VMD, DACVR