



RADIOLOGY REFERRAL FORM

Name of client: _____ Has the pet been seen at AAMC before? Yes No

Species/Breed: _____ Age: _____ Sex: _____ Weight: _____

Name of pet: _____

Prior health problems: _____

Complaint/Current problem: _____

What diagnostic tests were done? _____

Please list treatment for current problem (if any): _____

Specific questions about films sent? _____

Referring veterinarian/clinic: _____

Phone Number: _____ Fax Number: _____ Email: _____

Payment: The referral charge is \$50.00 per case. CT/MRI charge is \$75. Rechecks or additional views are read for no additional fee. You may enclose payment by check or be billed monthly.

NOTE: Please direct all films to **RADIOLOGY** at **Angell Animal Medical Center**, 350 South Huntington Ave., Boston, MA, 02130, whether sending them by courier, US Mail or express carrier. Disks will not be returned to practice/clinic.

PLEASE MAKE SURE RADIOGRAPHS ARE LABELED WITH PATIENT AND HOSPITAL NAME SO THAT WE CAN RETURN THEM