angell
Kindness and Care for Animals®

Radiology Referral Request Form

Date: _____

Referring Veterinarian: _____

Clinic Name and Address: _____

_____

Phone and Fax: _____

Owner Name: _____ **Animal Name :**_____

Species:_____ **Breed:** _____ **Sex:**_____ **Age:**_____

Prior Health Problems:

_____

_____

Diagnostic tests performed, results if applicable:

_____

_____

Clinical History/Signs:

_____

_____

_____

_____

_____

_____

_____

Please list treatment for current problem (if any):

_____

_____

Specific questions about films sent:

_____

_____

_____

Payment: The referral charge for radiographs is $61/case, limit 10 radiographs. You may enclose payment by check or be billed monthly. There is no STAT turnaround for mail in referral service.

NOTE: Please direct all films to **RADIOLOGY at Angell Animal Medical Center**, 350 S Huntington Ave., Boston MA, 02130, whether sending them by courier, US Mail, or express carrier. Disks will not be returned to you. For digital imaging, please consider using our online consultation service. Call 617-541-5139 or check our website www.angell.org for further information.

PLEASE MAKE SURE ALL RADIOGRAPHS ARE LABELLED WITH PATIENT & HOSPITAL NAME SO WE CAN RETURN THEM TO YOU!