North Downs
specialist referrals

Outpatient Imaging Service Form

Veterinary Surgeon's Details (About You)

* Denotes a required field

Title:	First Name:*	Your Last Name:*
Practice Name:*		
Practice Address Line 1:*		
Practice Address Line 2:		
Practice Address Line 3:		
Town:*	Postcode:*	Country:*
Practice Telephone Number:*		
Email Address* (NB: each user from a practice requires a unique email):		

Owner's Details

* Denotes a required field

Title:	Owner's First Name:	Owner's Last Name:*
Owner's Address Line 1:*		
Owner's Address Line 2:		
Owner's Address Line 3:		
Town:*	Postcode:*	Country:*
Owner's Telephone Number:*	Owner's Mobile Number:*	
Email Address*:		

Patient's Details

* Denotes a required field

Patient's Name:*	Patient's Last Name:*
Species:* ☐ Dog ☐ Cat	
Breed (if applicable):	
Gender: ☐ Male ☐ Male/N ☐ Female ☐ Female/N	
Date of Birth (DD/MM/YYYY) / Age (Years/Months):	

Details of Referral

* Denotes a required field

Imaging procedure:* ☐ Ultrasound ☐ CT ☐ MRI

Please attach blood results from the last 2 weeks if sedation or anaesthesia required

For CT and MRI procedures: I certify to the best of my knowledge this patient is safe to undergo routine sedation or anaesthesia where required:

☐ Yes ☐ No

Please return this completed form via fax on **01883 740154**

Committed to excellence

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Details of Referral *(continued)*

** Denotes a required field*

*Exact Area to be Investigated:**

*Main Complaint:**

*Duration of Signs:**

*Other Relevant History:**

*Suspected Differential Diagnosis:**

Please attach any image reports if available.

Please return this completed form via fax on **01883 740154**

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