

VCA Advanced Veterinary Care Center

Specialty & Emergency

15926 Hawthorne Blvd., Lawndale, CA 90260

310-542-8018 avccla@vca.com

CT Referral Form

- Outpatient (Ct Only) Consultation W/Ct

Attention Referring Veterinarian: Outpatient CT scans available Sunday through Saturday (call prior to check availability). Exams prior to anesthesia or sedation will be performed by a doctor. New client appointment is required for referrals that include consultations (Consultation w/ CT). **This form must be filled out in its entirety prior to the CT scan being performed.** The CT interpretation report will be faxed to your hospital.

Email Results to (please provide): _____ Date: _____

Client:

Name _____

Address _____

City _____ State ____ Zip Code _____

Phone Number _____ Is this animal known to be aggressive? Yes No

Referring Veterinarian _____ Hospital/Clinic Name _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____ Email _____

Patient:

Name _____ Species _____

Breed _____ Sex _____ DOB _____

CT Scan Study Type: (if more than one box is checked, then additional site charge will apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Nasal Passages | <input type="checkbox"/> Soft tissue Neck | <input type="checkbox"/> Tympanic Bulla |
| <input type="checkbox"/> Skull | <input type="checkbox"/> Mandible | <input type="checkbox"/> Maxilla | |
| <input type="checkbox"/> Spine - Cervical | <input type="checkbox"/> Spine - Thoracolumbar | <input type="checkbox"/> Spine - Lumbar | <input type="checkbox"/> Spine - Caudal |
| <input type="checkbox"/> Thorax | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbows |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Stifles | <input type="checkbox"/> Tarsi | |
| <input type="checkbox"/> Brachial Plexus | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Soft Tissue – mass, location: _____ | <input type="checkbox"/> Other: _____ |

Pertinent history, reason for the study, clinical signs: _____

History of seizures or other concerns? _____

Any anesthetic concerns? _____

Email Results to: avccla@vca.com

