VCA Northwest Veterinary Specialists

16756 S.E. 82nd Drive, Clackamas, OR 97015

P 503-656-3999 nwvsrecords@vca.com

CT/MRI Referral Form

When scheduling for an MRI or CT, the patient drop off is between 7:30 and 8 a.m. Because we are associated with an emergency hospital, imaging times are always subject to change as critical cases may take priority according to medical need.

In order to ensure that your patient is imaged in a timely manner, please perform all pre-anesthetic workup prior to sending the case. *If the pre-anesthetic workup is not done, the patient may need to be rescheduled to a different day.*

Pre-anesthetic workup includes:

1. Three view thoracic radiographs for animals older than 5 years of age, or any age animal with concern for cardiopulmonary disease, within a month of the procedure.
2. CBC and chemistry panel within a month of the procedure.
    a. Please note: if there are health status changes between the time of bloodwork and the time of appointment, more current labwork may be indicated.

If there are any concerns or logistical difficulties with performing these pre-anesthetic tests, please call to speak with the radiologist supervising the case before scheduling.

Please fill out our referral form with a detailed description of the case and email to **nwvsrecords@vca.com**, or fax to (503) 557-8672, along with labwork, radiographs, recent patient records, radiograph reports, etc. at least 24 hours prior to the scheduled appointment.

Should you have any questions, please feel free to contact the imaging team: (503) 656-3999.

Thank you for your referral

Sincerely,

Imaging Department
Referral Coordinator
VCA Northwest Veterinary Specialists
P. 503-656-3999
F. 503-557-8672
E. nwvsrecords@vca.com

vca animal hospitals SPECIALTY CARE

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CT/MRI Referral Form

RDVM Information:

Date: _____ Date of IMG: _____

Referring Doctor: _____ Referring Hospital: _____

Hospital Phone Number: _____

How would you like to be informed of the results?

❑ Fax _____ ❑ E-mail _____ ❑ Other _____

Client Information:

Client Name: _____ Contact Phone Number: _____

Patient Information

Pet Name: _____ ❑ Dog ❑ Cat Breed: _____

Sex: ❑ FS ❑ MN ❑ F ❑ M Age/Birthdate: _____ Patient wt. _____ ❑ kgs. ❑ lbs.

Exam(s) Requested:

❑ MR – region to examine _____

❑ CT – region to examine _____

Radiation Therapy Positioning with CT ❑ No ❑ Yes

Patient History, Lab Results, Clinical Findings, Recent Therapy: (Please fill out even if faxing records)

Anesthetic concerns? ❑ No ❑ Yes _____

Precautions (may bite/other): _____

Recent Radiographs ❑ No ❑ Yes - ❑ emailed (nwvsrecords@vca.com)

Recent Bloodwork ❑ No ❑ Yes - attach please ❑

Recent Urinalysis ❑ No ❑ Yes - attach please ❑

The following estimate has been provided to the client: $_____

(Payment will be due at the time of drop-off)

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