1535 S Sepulveda Blvd, Los Angeles, Ca 90025
Emergency & Critical Care | 310-473-1561
Specialty | 310-473-5906
Fax | 310-479-8976
ASECvets.com

DIAGNOSTIC IMAGING REFERRAL FORM

Client name: ____ **Pets name**: ________________

Age: ______________________ **Sex**: M MC F FS **Breed:** ________________________

Primary Vet: _________________________________ **Hospital:** ___________________________

Do you prefer the report faxed, emailed, or both? ______________________________________

Please provide the preferred fax number and/or email address:

Fax#: ___________________________ **Email:** _______________________________________

Pertinent history, physical findings, and lab findings:

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Please circle requested imaging:

Ultrasound → Abdomen Cervical Thorax (non-cardic)

CT → Skull Cervical or Thoracolumbar spine

Thorax Abdomen Pelvis Elbow

Other: ____

Radiographs → Thorax Abdomen

Other: ____

***Please send this completed form along with all medical records, including lab work and imaging, to ASECreception@vca.com. Alternatively, you can fax records to 310-479-8976.**