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DATE: \_\_\_\_\_

**RADIOLOGY PATIENT REFERRAL INFORMATION**

Radiographic Consult

Ultrasound Referral:

Referring Veterinarian: \_\_\_\_\_

Clinic/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Daytime Telephone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

Evening Telephone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

Preference for Initial Communication: \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Both

**Client** Name: \_\_\_\_\_ Date radiographs were taken: \_\_\_\_\_

**"Pet"** Name: \_\_\_\_\_  Canine  Feline Breed \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Presenting Complaint: \_\_\_\_\_

History: \_\_\_\_\_

Physical Examination Findings: \_\_\_\_\_

Pertinent Laboratory Results: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Differential Diagnosis/Reason for Referral: \_\_\_\_\_

\_\_\_\_\_ Send Request Forms \_\_\_\_\_ Payment Enclosed \_\_\_\_\_ Bill Me