

**KLINIKA DLA MAŁYCH ZWIERZĄT WĄSIATYCZ SP. Z O.O.**

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KRS 0001090618

REFERRAL FOR COMPUTED TOMOGRAPHY SCAN						CT			
city / town					date				
REFERRING VETERINARIAN *		veterinarian's stamp							
phone *					e-mail *				
PATIENT DATA (ANIMAL) *					OWNER / GUARDIAN DATA *				
name		sex **		☐ ♀	☐ ♂	Full name			
date of birth or age		weight				address			
species **		Ca ☐ Fe ☐ other ☐		neutered / spayed**		yes ☐	no ☐	phone	
breed		microchip / metal implants **		yes ☐	no ☐	e-mail			
PURPOSE OF EXAMINATION / DIAGNOSIS / SUSPICION *									
MEDICAL HISTORY *					CURRENT MEDICATIONS *				
ATTACHED MEDICAL DOCUMENTATION *									
PLEASE PERFORM ADDITIONAL TESTS **									
CBC + Blood Biochemistry ☐ (performed within a maximum of 7 days prior to the CT scan)				X-ray ☐	Ultra-sound ☐	HP ☐	OTHER		
PLEASE PROVIDE ADDITIONAL CONSULTATIONS **									
CARDIOLOGY ☐		NEUROLOGY ☐		ORTHOPEDICS ☐		OTHER			
IMPORTANT: DETAILED CT SCAN AREA WITHIN: **									
HEAD ☐		NECK ☐		CHEST ☐		ABDOMEN ☐		PELVIS ☐	
SPINE - LEVEL:		C1 - Th2 ☐	Th3 - L3 ☐	L1 - S3 ☐	C1 - S3 ☐	LIMB THORACIC RIGHT ☐ LEFT ☐		PELVIC RIGHT ☐ LEFT ☐	
OTHER									
URGENT EXAMINATION AND REPORT: YES ☐ NO ☐									
Date, signature, and stamp of the referring veterinarian									

* Mandatory fields

** Mark the appropriate boxes with an "X"

NOTE: **A SEPARATE FEE IS CHARGED** FOR EACH EXAMINED AREA, ADDITIONAL TEST, AND CONSULTATION (EACH MARKED BOX).

PRIOR TO THE CT SCAN, THE ANIMAL MUST BE FASTED FOR AT LEAST 12 HOURS AND MUST NOT BE GIVEN WATER FOR 4 HOURS.