



**PSM Outpatient CT Referral Form** Please include (1) original radiographs and (2) copies of all pertinent laboratory results (3) copy of pertinent medical record. Thank you for your referral.

*Information for Referring Veterinarians: Outpatient CT is appropriate for stable, nonemergent patients who are healthy enough for sedation or anesthesia. You will receive a radiology report and images via email.*

- Please ensure your client understands that an Outpatient CT Referral does not include client consultation with the Internist or Surgeon.*

<b>rDVM Information</b>		Date:
Referring Doctor:		Phone:
Hospital Name:		Fax:
Hospital Address:		Best Time To Call:
Would you like an email copy of the entire study:    Yes        No		Email Address:

**Client Information**

Owner Name:		
Owner Address:		
Pet's Name:	Species:    Canine        Feline	Anesthetic Risk Classification 1   2   3   4   5   emergency
Breed:	Birthdate (Best estimate):	Weight:
Current on vaccinations:    Yes        No	Spayed/Neutered:    Yes        No	Sex:        Male        Female

**Clinical Concerns & Actions**

Presenting problem or rule outs: (please be specific on what you are looking for or want to rule out)

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CT Region Requested – *Please check the region(s) to be scanned (call if you have questions):*

Head/Brain                       Bullae & Ears                       Nasal Passages  
 Cervical spine                       Brachial Plexus                       T-L spine                       L-S spine  
 Chest                       Abdomen                       Limb (specify joint, right or left, front or back): \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

List any specific imaging questions to be sent to the radiologist:

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History / Pertinent Findings (PE, Labs, Imaging) / Treatment / Current medications:

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Does this patient have any renal impairment:

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Recent anesthesia or surgery: Yes or No (please explain):

I have reviewed and completed this form for submission to Pet Specialists of Monterey for the care of my patient. I understand that PSM doctors and staff will follow my specific treatment and evaluation directives unless patient condition changes. Once patient is transferred to PSM, PSM has authority to use their best judgment in determining appropriate course of treatment for my patient.

Signature	Date:
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