Specialist Referral Form for PetCure Oncology at VRIC

DVM Name:	Date:
Specialty: Oncology □ Internal Medicine □	Owner Name:
Surgery □ Neurology □ Cardiology □	Owner Phone:
Dermatology □ Dentistry □ Other____________	Owner Email:
Hospital Name:	Owner Address:
Phone: ( )	Patient Name: Weight:
Fax: ( )	Breed: Species:
DVM Email:	Sex: FS □ FI □ MN □ MI □ Age:

Patient's pertinent laboratory, historical and physical exam findings

Historical Summary ____

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Current Medications: ____

Previous anesthetic complications:____

Minimum medical database requested

Please provide copies of RECENT test results: CT □ MRI □ CBC □ Chem Screen □ T4 □
Urinalysis □ Thoracic radiographs □ US results □ Coag and CBC, if biopsy requested □

Study Type

Please contact our staff prior to referral for imaging if you have any questions regarding the imaging method of choice and/or estimates

Anatomical Region(s) to Scan:____

CT □ CT for Radiation Therapy Planning □ MRI □ Ultrasound □ Biopsy or FNA, if possible □

Service Requested/Goal of Study:____

Radiation Therapy

For specialists outside of oncology, please provide all available imaging to assist with our radiation oncology consult.
If you are an oncologist, please indicate whether you would like a video consult prior to referring. Yes □ No □