



POOLER VETERINARY HOSPITAL

OUR FAMILY CARING FOR YOURS

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Ultrasound Referral Request Form

Referring Veterinarian: _____

Hospital: _____ Phone: _____

Fax: _____ Date Exam Req: _____

Client Name: _____

Phone Number: _____

Pet's Name: _____ Breed: _____

Age: _____ Sex: _____ Weight: _____

Presenting Complaint: _____

Current/Recent Medications: _____

Lab Results/Pending Tests: _____

(Please attach copy of results when possible)

Radiographic Findings: _____

(Please send copy of radiographs for best case management when possible)

Diagnosis or Rule-Out: _____

Ultrasound Study Requested (abdominal, echocardiogram, pregnancy): _____

Additional Tests Requested (sterile urinalysis, blood pressure, ECG, fluid analysis, centesis, etc.): _____

Is sedation/anesthesia possible if needed (or please indicate if you know it will be necessary.)? _____

Also, please note any limitations or previous problems with anesthesia: _____

Ultrasounds are scheduled according to availability for the date requested. Please note that at this time ultrasound referrals are available on Tuesdays and Wednesdays. Additional tests may require pre-anesthetic bloodwork, such as clotting profiles, CBC, SAP, etc. Dr. Dasher may need to discuss the case with the referring veterinarian prior to the ultrasound date to ensure that tests requested are possible and yield best results.