



OUTPATIENT IMAGING REQUEST FORM

radiology@dcvetreferral.com

6700 Laurel-Bowie Rd. (rt.197) Bowie, MD 20715

301-809-8800

301-809-0900

www.dcvetreferral.com

Imaging requested: **CT** **Ultrasound**

REFERRING INFORMATION

Date: _____

Doctor: _____

Hospital: _____

Phone Number: _____

Fax Number: _____

Email: _____

CLIENT & PATIENT INFORMATION

Client: _____

Address: _____

Phone Number: _____

Patient Name: _____

Patient D.O.B: _____ Species: _____

Breed: _____ Sex: M MC F FS

REASON FOR REFERRAL: _____

BODY AREA REQUESTED: _____

If aspirates or stabilization are required, please contact the radiology department at (301) 809-8800 prior to referral

DIAGNOSTICS PROVIDED FOR REVIEW

Radiographs

Ultrasound

Lab Tests

Other _____

Please indicate how images and records are being sent
(Records may be faxed or emailed contact@dcvetreferral.com.
Images may be sent to radiology@dcvetreferral.com)

Please utilize this form as a fax cover sheet for medical records. Fax to (301) 809-0900