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: ______________________

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Phone Number: ______________________

Fax Number: ______________________

Email: ______________________

CLIENT & PATIENT INFORMATION

Client: ______________________

Address: ______________________

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Phone Number: ______________________

Patient Name: ______________________

Patient D.O.B: __________ Species: __________

Breed: __________ Sex: M ☐ MC ☐ F ☐ FS ☐

REASON FOR REFERRAL: ______________________

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BODY AREA REQUESTED: ______________________

***If aspirates, sedation 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)

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