



Phone: 608-845-0002
Fax: 608-845-2200



RADIOGRAPH CONSULTATION REQUEST

Patient Information

Pet Name _____ Age _____ Sex _____ Breed _____ Weight _____

Referring Veterinarian Information

Name _____ Clinic _____

Address _____

Phone _____ Fax _____

Patient history: _____

Physical exam findings: _____

Previous diagnostics: _____

Medication/response: _____

Radiographic views (including dates and initial findings): _____

Thank You for your referral!
Radiographs will be returned promptly

Fee will be noted on invoice that accompanies the radiographic report (if applicable)

For more information visit Veterinary Specialty & Emergency Care at www.vetspecialtycare.com