BOUNDARY BAY
VETERINARY SPECIALTY HOSPITAL

DIAGNOSTIC IMAGING
(Ultrasound / Echo)
REFERRAL REQUEST
Dr. Alexandra Bratton, Dipl. ACVR

URF2

Do not write in this area

Referring Hospital	Referring Veterinarian	DATE
rDVM Phone Number ☆	Alternate Phone Number if necessary:	

Dr. Bratton will make every effort to contact rDVM by telephone following the requested procedure to discuss the results and recommendations. In the event that the rDVM is unavailable or cannot be contacted, Dr. Bratton will review findings with owner/agent and discuss procedures or referral if indicated. A written report will follow via fax or email.

CLIENT

Client Last Name	First Name	
Street Address	City	Postal Code
Home Phone	Cellular	Email

PATIENT

Name	Breed	Species	Sex M MN F FS	Age (MM / DD / YYYY)

RELEVANT HISTORY

Current Medical Concern(s)	**Primary Ddx or Diagnostic Question(s)**
1.	1.
2.	2.

Relevant History, Comments or Special Concerns

Previous Procedures Performed **Please have client bring results of these procedures*
(Radiographs, Ultrasound, Diagnostic Tests, Previous Consults)
Please email radiographs to: ***Radiology@BBVSH.com***

If radiographs have not been obtained or are not available, we may obtain them, if necessary.

Current Medications & Treatments

Follow-up

☐ Consult rDVM regarding additional diagnostics & continuing care

☐ Treat as needed at Boundary Bay Veterinary Hospital

REQUESTED PROCEDURES

Patient Name: _____

☐ **Abdominal Ultrasound**

☐ **Ocular Region/Eye**

☐ **Echocardiography**

☐ **Pregnancy Assessment**

☐ **Thoracic Cavity and Mediastinum –** This does not include an echocardiogram. This should be used to evaluate mediastinum, thoracic wall or pulmonary masses.

☐ **Other Area Examination (such as neck/thyroid, superficial masses, or musculoskeletal)**

Area Requested _____

***Please Note:**

- We do not perform partial abdominal ultrasounds.
- Please also note that the animal will be admitted to BBVSH if any complications arise from the procedures.
- Sedation may be required for ultrasound and/or procedures and will be performed as necessary with permission from the client. If pre-anesthetic blood work has not been performed, or is not available at the time of the appointment, we will perform it prior to sedation.

This section completed by BBVSH

APPOINTMENT CONFIRMATION

Appointment Date:		Appointment Time:
Clinic Name:	RDVM email address:	RDVM Fax #:

Appointment declined by client ☐

Confirmation Faxed ☐	Confirmation Emailed ☐	Completed By
Date	Time	

The doctor will make every attempt to contact rDVM by telephone following the requested procedure. In the event that the rDVM is unavailable or cannot be contacted, the doctor will review findings with owner/agent and discuss available procedures as indicated. A written report will follow via fax or email.

PLEASE CALL TO CONFIRM THAT WE RECEIVED THIS REQUEST.

Please ensure BOTH pages are completed and returned to our office by fax: 604-514-1712 or by email: bbvshlab@telus.net. *Once you have faxed your referral, we will contact your client to book an appointment. Confirmation will follow.*