



ILLINOIS

RDVM Outpatient Imaging Request Form

University of Illinois Urbana-Champaign

Veterinary Teaching Hospital

Phone: (217) 333-1800

Fax: (217)333-9796

Email: radconsults@vetmed.illinois.edu

Veterinarian:

Name: _____

Clinic: _____

Street: _____

City: _____ State: _____ Zip: _____

Ph: (____) _____ Fax: (____) _____

Email: _____

Client:

Name: _____

Clinic: _____

Street: _____

City: _____ State: _____ Zip: _____

Daytime Ph: (____) _____

Cell Ph: (____) _____

Email: _____

Has been a client at the VTH before: YES NO

Animal

Name: _____ Sex: _____ DOB: _____ Weight: _____ Species/Breed: _____

Medication Allergies: _____

Current Medications: _____

Modality: Ultrasound MRI CT Echocardiogram

Requested scan: _____

All patients should be NPO (no food) for 12 hours and no water for 3 hours prior to exam

Reason for test (sign, symptom, or complaint): _____

Previous diagnostics performed and results (please fax or email results to the above address) : _____

Previous Surgeries on the area of interest? : YES NO _____

Perform aspiration if indicated YES NO If yes, please discuss with client before appointment.

Special or Post scan instructions: _____

SEDATION:

Sedation is not routinely given unless the patient becomes aggressive or cannot be immobilized safely to perform the exam. Each case will be evaluated on an individual basis. Blood work performed within 2 weeks is required before sedation can be administered. Client consent is required before sedation can be administered. **Please indicate any contraindications for sedation** _____

Referring Veterinarian Signature: _____ Date: _____