



# rDVM Outpatient Imaging Request Form

University of Illinois Urbana-Champaign  
Veterinary Teaching Hospital  
Phone: (217) 333-1800  
Fax: (217) 333-9796  
contact

Email: radconsults@vetmed.illinois.edu

### Follow these steps:

1. Complete form
2. Fax to 217-333-9796
3. The imaging department will

your client to make the appointment.

<b>Referring Veterinarian:</b> Name: _____ Clinic: _____ Street: _____ City: _____ State: _____ Zip: _____ Ph: (____) _____ Fax: (____) _____ Email: _____	<b>Client:</b> Name: _____ Clinic: _____ Street: _____ City: _____ State: _____ Zip: _____ Daytime Ph: (____) _____ Cell Ph: (____) _____ Email: _____ Has been a client at the VTH before:    YES    NO
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**Animal**  
 Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_ Species/Breed: \_\_\_\_\_  
 Medication Allergies: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

Requested Radiographs: \_\_\_\_\_  
 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 \_\_\_\_\_

Referring Veterinarian Signature: \_\_\_\_\_ Date: \_\_\_\_\_