



SOUTH TEXAS VETERINARY MRI

Referral Form

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Phone: 210-858-0162

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PET INFORMATION

Pet's Name: _____

Owner's Name: _____

Owner's Phone Number: _____

Owner's Address: _____

Date of Birth: _____

Species: Dog Cat Other (specify): _____

Breed: _____

REFERRING VETERINARIAN INFORMATION

Today's Date: _____

Referring Veterinarian: _____

Mailing Address: _____

Phone Number: _____

FAX: _____

Sex: Female Male

Patient's Weight: _____

1. TYPE OF MRI ORDERED

- | | | | | | |
|------------------------------------|--|---|--|-------------------------------------|-----------------------|
| SPINE | BRAIN | HEAD/NECK | LIMB/JOINTS | SOFT TISSUE | OTHER(specify) |
| <input type="checkbox"/> C1-T2 | <input type="checkbox"/> Brain | <input type="checkbox"/> Nasal cavity | <input type="checkbox"/> Brachial plexus (L/R) | <input type="checkbox"/> Abdomen | _____ |
| <input type="checkbox"/> T3-L3 | <input type="checkbox"/> Brain + C1,C2 spine | <input type="checkbox"/> Osseous bullae | <input type="checkbox"/> Lumbosacral plexus | <input type="checkbox"/> Chest wall | _____ |
| <input type="checkbox"/> L4-sacrum | | <input type="checkbox"/> Orbits | <input type="checkbox"/> Stifle (L/R?) | | _____ |
| <input type="checkbox"/> T3-sacrum | | <input type="checkbox"/> Sinuses | <input type="checkbox"/> Elbow (L/R?) | | |
| <input type="checkbox"/> C1-sacrum | | <input type="checkbox"/> TMJ | <input type="checkbox"/> Hip (L/R?) | | |
| | | <input type="checkbox"/> Soft tissue neck | <input type="checkbox"/> Pelvis (L/R?) | | |
| | | | <input type="checkbox"/> Shoulder (L/R?) | | |

3. REASON FOR MRI:

4. DOES THE PATIENT HAVE OR HAS THE PATIENT HAD ANY OF THE FOLLOWING (if yes, please provide details):

- Yes No Cardiac Pacemaker: _____
- Yes No Brain Surgery: _____
- Yes No Shunts/Stents/Filters/Intravascular Coil: _____
- Yes No Orthopedic Pins/Screws/Rods/Joints/Prosthesis: _____
- Yes No History of Cancer or Tumors: _____
- Yes No Radiation Therapy/Chemo Therapy: _____
- Yes No Previous Back Surgery (Cervical/Thoracic/Lumbar): When: _____ Implants placed? _____ Levels: _____
- Yes No Gunshot Wounds / BB: _____
- Yes No Is the pet micro-chipped? If yes, when: _____
- Yes No Ingestion of any metal object? _____
- Yes No Screening radiographs for embedded metal? _____

5. LIST PREVIOUS SURGERIES

PLEASE FAX THIS ORDER TO: 210-858-0164