Friendship Hospital for Animals
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OUTPATIENT ABDOMINAL ULTRASOUND REFERRAL

Please fill out and e-mail to fdi@friendshiphospital.com

Referring veterinary hospital: _____
Contact doctor: _____
Phone: _____ E-mail: _____
Other preferred contact information: _____
**Report will be emailed unless otherwise indicated*

Client Name: _____ Client phone: _____

Patient name: _____ Patient signalment: _____

Brief History *(This history will be used in the finalized ultrasound report)*:
_____
_____
_____

Radiologist to go over ultrasound findings with client: Yes___ No___

**Please inform the client to withhold food the day of the ultrasound (water is okay)*

**Feel free to contact us via our direct line or e-mail at any time*

**If possible, please attach the patient's medical record with this form*