



FAX REFERRAL FORM

THE ANIMAL ULTRASOUND CLINIC

131 Boston Street  
Salem, MA 01970

352 Warren Ave  
Portland, ME  
04062

T 978-740-9800  
T 800-755-7595  
F 978-740-9945

REFERRING HOSPITAL:  
The Animal Ultrasound Clinic  
Salem, MA 01970

Referring DVM: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Contact person phone numbers:

Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

Preferred procedure date: \_\_\_\_\_

MON TUE WED THU FRI SAT (Circle one)

Transportation: AUC CareLink Van Owner  
Referring Hospital Staff

Patient's Name: \_\_\_\_\_

Breed: \_\_\_\_\_

Color/features: \_\_\_\_\_

DOB: \_\_\_\_\_ Wt: \_\_\_\_\_ Sex: \_\_\_\_\_

Rabies status: Current Not current Unknown

Procedures requested (please circle):

- |                       |                                      |  |
|-----------------------|--------------------------------------|--|
| 1. Echocardiogram     | 8. Lower GI Endoscopy                | 14. Ultrasound-guided biopsy of<br>_____<br>(please specify) |
| 2. Thoracic Sonogram  | 9. PEG tube placement                |  |
| 3. Abdominal Sonogram | 10. PEG tube removal                 |  |
| 4. Holter ECG         | 11. Rhinoscopy                       |  |
| 5. ECG                | 12. Bronchoscopy/ bronchial aspirate | 15. Other Sonogram:<br>_____<br>(please specify)             |
| 6. BP                 | 13. Cystoscopy                       |  |
| 7. Upper GI Endoscopy |                                      |  |

Pertinent medical history (summary please):

CBC/profile/UA/other:

Radiographic findings:

Particular questions you would like answered:

Please fax (978-740-9945) this completed form 24 hours prior to appointment.

Please send along pertinent radiographs and bloodwork, but not your medical record. If The Animal Ultrasound Clinic is to provide transportation, please have the owner sign our AUTHORIZATION AND CONSENT FORM. The CONSENT FORM and the REFERRAL FORM must be received by our office prior to pickup. Please have the patient in hospital by 8:00 AM for CareLink van transportation.

Thank you.

Referral Form 4/06