Fairview
Animal Hospital

7071 Bayers Rd
Halifax, NS B3L 2C2
T: 902.443.9385 | F: 902.445.4307
info@fairviewanimalhospital.com
www.fairviewanimalhospital.com

Ultrasound Referral Form

Referring Hospital: ____ Veterinarian: ______________________________

Phone Number: ______________________ Fax: __________________ Email: _________________________________

Stat: ☐

CLIENT INFORMATION

Name: ____

Address: ____

Contact Number: ______________________ Email: ____

PATIENT INFORMATION

Name: ____________________________ Breed: ______________________ D.O.B: ___________________________

Sex: ☐ M ☐ F Neutered/Spayed: ☐ Yes ☐ No Colour: ________________ Weight: ______________

Allergies: ____

Relevant History:

A 12-hour fast period is required prior to the ultrasound. Water is allowed and if possible, we would like a full bladder. The ultrasound appointment will take approximately 1 hour. Results are sent to the referring veterinarian as soon as possible. We kindly ask that you send any important information related to this case, along with the referral form, via fax or email. Please indicate below how you would prefer to receive results. We are happy to answer any questions you may have. Thank you for entrusting us with the care of your patient.

Who will be setting up the appointment? ☐ Client ☐ Referring Clinic ☐ Fairview Animal Hospital

Has this appointment already been scheduled for this client at Fairview Animal Hospital? ☐ Yes ☐ No

I would like test results sent to me via: ☐ Fax ☐ Email

Requested by: ____ Date: ___________________________________