ULTRASOUND REFERRAL FORM

DR. GERI REIMER
Central Valley Veterinary Hospital
#124-1940 Kane Road
Kelowna, BC V1V 2J9
ph: 250-762-7181
email: centralvalleyvet@shaw.ca

Patient Information:

Name: DOB:
Breed: Colour:
Sex: Weight:

Client Information:

Name:
Address:
Phone #:

Presenting Complaint:

Pertinent Information / Clinical Findings / History:

Temperament:
Ultrasound Request:
Abdominal ☐
Cardiac ☐ **Murmur present: Yes** ☐ **No** ☐ **Grade:** ___ **Average Blood Pressure:** ____
Fine Needle Aspirate ☐ **Biopsy** ☐
(all FNA/Biopsies need a PT/PTT performed by referring DVM prior to appointment)

Referring Veterinarian:
Name:
Clinic:
Phone #:

*****Please fill out and email or fax back to us along with any recent BLOOD WORK and RADIOGRAPHS.*****

Thank you for your referral.
Dr. Geri Reimer, DVM

centralvalleyvet@shaw.ca

fax 250-762-7183