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RADIOGRAPH REFERRAL FORM

Michael E. Roy, DVM, MS, Diplomate ACVR

Please include this completed form with your radiographs for review.

Date: _____

Referring Veterinarian's Name: _____

Hospital Name: _____

Phone: ( ) _____ Cell/Other: ( ) _____ Email: _____

Client Name: _____

Home Phone: ( ) _____ Cell/Other: ( ) _____

Patient's Name: _____ Species: _____

Breed: _____ Sex: _____ Age/DOB: _____

Number of films sent: _____

Radiographs to be reviewed: _____

_____

_____

Brief History or
Areas of Concern: _____

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You may expect a telephone call the same day and a faxed copy of the radiographic report within 24 hours of the radiographic review. All radiographs will be returned promptly. Digital films on CD will not be returned unless requested.

Thank you for your referral.