

Animal Medical Clinic, P.C.
4296 University Dr. NW
Huntsville, Al 35816
(256)837-9700
(256)864-0868fax

Ultrasound Referral Form

Patient's Name _____
Owner's Name _____
Species _____
Patient's DOB _____
Breed _____
Sex _____
Color & Markings _____
Vaccine History _____

Type of Ultrasound Requested _____
Pertinent
History _____

Medications &
dosages _____

Do you wish this ultrasound to be sent for telemedicine services? (Circle one) Yes / No

Please send ALL blood work and Radiographs, along with this form, with your client the day of their pet's ultrasound. All patients must be fasted for 12 hours prior to the day of the exam. Failure to provide a history and necessary information may result in delays for your clients and possibly cancellation of their appointment.

Referring DVM: _____
Phone number to reach referring DVM the day of the
procedure: _____