NEWCASTLE VETERINARY ULTRASOUND – ABDOMINAL REFERRAL

Practice:	
Referring Veterinary Surgeon: Dr.	Date:

Owners Name:		
Owners Contact Number(s), email:		
Patient Name:	Canine/Feline:	
Breed:	Weight:	kg.
Age/Date of Birth:	Sex: F FN M MN	

History:
Clinical signs, duration:
Pertinent lab results [including previous results if rising levels]
Clinical Diagnosis or ddx:
Would FNA [eg. liver, mass] or cystocentesis be required? Yes / No
Current and chronic medications:
Is sedation permitted? [fractious cases to be sedated by the RV]: Yes / No

Please call Kerry on 0429799856 to book all appointments then scan and e-mail referral form within 24hrs to secure your booking to:

rossbarter@newcastleveterinaryultrasound.com.au OR keznross@bigpond.net.au

Please attach any recent lab results and X-rays