Clear Form

SUBMIT

DIAGNOSTIC IMAGING REFERRAL FORM

FOR OFFICE USE ONLY

REFERRAL NUMBER

DATE RECEIVED

DATE MAILED

VETERINARY TEACHING HOSPITAL

DIAGNOSTIC IMAGING SECTION
1002 OTT ROAD · PO BOX 647060
PULLMAN, WA 99164-7060
509-335-6980 Fax: 855-883-4536
radiology@vetmed.wsu.edu

PLEASE TYPE OR PRINT CLEARLY

Referring Veterinarian _____ Phone: _____

Clinic: _____ Fax: _____

Address _____ Email: _____

City, State/Province, Zip _____ _____

BILLING OPTIONS: ☐ Send Invoice ☐ Call for Credit Card Number

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ALL IMAGES MUST BE SUBMITTED AS DICOM. (We cannot evaluate .jpeg or .tiff images)
ON IMAGES, PLEASE INCLUDE: ID marker w/ patient & clinic name, times for barium/IVP studies

☐ Follow-Up Study Date(s) of Images: _____ Number of Images: _____

Patient Name: _____ Owner: _____

Species: _____ Breed: _____ DOB: _____ Sex: _____

CLINICAL CONCERN:

RELEVANT HISTORY: