Fox Valley
ANIMAL REFERRAL CENTER

Radiograph Referral Form / Report

FVARC USE

Date rcvd: _____
# of films / size: _____
# of films / size: _____
# of films / size: _____
Checked in by: _____

USE THIS FORM WHEN REQUESTING A RADIOGRAPH REVIEW BY OUR RADIOLOGIST

REFERRING HOSPITAL

Referring veterinarian: _____ Date: _____ # of films: _____

Hospital name: _____ Phone: _____ Fax: _____

Patient name: _____ Client name: _____

Species: _____ Breed: _____ Sex: _____ Age: _____

Pertinent clinical history (use back if necessary):

FOX VALLEY ANIMAL REFERRAL CENTER **(Please do not write below this point, for FVARC use only.)**

Radiographic findings:

Thank you for this referral. If I can be of further assistance, please do not hesitate to call.

Sincerely,

_____ _____
Date

Faxed to RDVM
Date: _____
Time: _____
By: _____
☐ billed
☐ do not bill
per _____

☐ Films are being held at Fox Valley Animal Referral Center

4706 New Horizons Boulevard, Appleton, WI 54914 920-993-9193 fax 920-993-8492