DISCOVERY
ANIMAL IMAGING
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P.O. Box 16391
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discoveryanimalimaging.com

IMAGING REQUEST FORM

Veterinarian Info

Name:
Clinic/Hospital:
Tel:
Address:
Email:

Patient Info

Owner (First/Last):____
Patient Name:__________________________Sex: O **M** O **NM** O **F** O**SF**
Species/Breed:__________________________Age:_________Weight:_________

TYPE OF IMAGING REQUESTED

O **Skull CT** O **Thoracic CT** O **Pelvis CT** O **Appendicular CT**
O **Cervical spine CT** O **Thoracic spine CT** O **Lumbar Spine CT**
O **Fluoroscopic study**

REASON FOR IMAGING:

PATIENT HISTORY:

AUTHORIZATION:
I verify that I am the owner (or Authorized agent for the owner) of the above named pet and authorize the above procedure to be performed. I have been advised of the nature of this procedure to be performed and the risks involved.
Signature of Owner or agent:________________________________**Date:**____________________

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