OUTPATIENT CT REQUEST FORM

Please complete the form in **black ink**, attach clinical history including diagnostic results and images and email to: **referrals@eden-vets.co.uk**

TURNAROUND REQUIRED FOR IMAGING REPORT

Standard 3 - 5 days ☐ Priority upto 24 hrs* ☐ Urgent upto 4 hrs* ☐ *fees applicable

PRIMARY CARE PRACTICE DETAILS

Referring Vets Name:

Telephone:

Email:

Referring Vet Practice:

Address:

Postcode:

PLEASE NOTE REPORTS AND LETTERS WILL BE EMAILED TO YOUR PRACTICE ON THE EMAIL ADDRESS GIVEN

OWNERS DETAILS

Owners Name:

Telephone:

Email:

Insured:
Yes ☐ No ☐ Company:

Address:

Postcode:

Policy No. (if known) :

Limit: (if known)

PATIENT DETAILS

Name:

Age/DOB:

Sex:

Species:

Breed:

AREA TO BE SCANNED

Head ☐ Thorax ☐ Abdomen ☐

C1-T2 Spine (inc brachial plexus) ☐ T3- Tail ☐

One joint both left & right ☐

Forelimb (inc 3 paired joints) ☐

Hindlimb (inc 3 paired joints) ☐

Additional contrast study ☐

Information about imaging or patient management to be asked/answered:

Contrast for pre & post images Yes ☐ No ☐

Relevant clinical history, clinical findings and diagnostic test results:

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Address: Bloore House, 416 Newcastle Road, Shavington, Crewe CW2 5JF