Veterinary Imaging Services at Powers Pet Emergency
Outpatient Imaging Referral Form

**** PLEASE COMPLETE THIS FORM AND RETURN VIA FAX 719-434-9502 OR EMAIL imaging@powerspetemergency.com****

Referring Veterinarian

Referring DVM: _____

Hospital Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____

Preferred Method of Contact: Phone / Fax / E-Mail

Patient Information

Owner's Name: _____

Pet's Name: _____

Species: _____ Breed: _____

Age: _____ Sex: M / NM / F / SF

Diagnosis: _____

Previous Medical Conditions: _____

_____

Requested Exam:

_____

_____

_____

PLEASE SEND / BRING ALL PERTINENT X-RAYS, LABWORK, AND MEDICAL RECORDS FOR SUBMISSION TO THE RADIOLOGIST.
THE RESULTS OF THE IMAGING EXAM WILL BE REPORTED TO THE REFERRING VETERINARIAN.

Brief Medical History:

_____

_____

_____

Latest Treatments / Medications Administered:

_____

_____

_____

Pertinent Lab Work:

_____

_____

_____

5886 Tutt Blvd / Colorado Springs, CO 80923 / 719-473-0482