

# GatorVetImaging Small Animal CT Request Form

Phone: (352) 273-8585   Fax: (352) 294-9877   Email: GVI@vetmed.ufl.edu   Website: www.GatorVetImaging.com

## Client, Patient, and Veterinarian Information:

### Client and Patient

Client Name: \_\_\_\_\_  
 Address, Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Client Phone(s): \_\_\_\_\_  
 Patient Name: \_\_\_\_\_

### Veterinarian

Veterinarian: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

Species:    Dog    Cat    Other, Specify: \_\_\_\_\_   Sex:    Female    Female Spayed    Male    Male Neutered  
 Color: \_\_\_\_\_   Weight (kg): \_\_\_\_\_   Date of Birth: \_\_\_\_\_  
 Breed: \_\_\_\_\_   Date Last Rabies Vaccine: \_\_\_\_\_

## CT Image Request: Check Area to be Imaged

<b>Spine</b> (\$660 one area, \$945 two areas) <input type="checkbox"/> C1-T2 <input type="checkbox"/> T3-L3 <input type="checkbox"/> L4-sacrum <input type="checkbox"/> T3-sacrum <input type="checkbox"/> C1-sacrum <input type="checkbox"/> Lumbosacral Plexus	<b>Brain</b> <input type="checkbox"/> Brain (\$685)  <b>Angiogram</b> (\$720) <input type="checkbox"/> Portosystemic shunt <input type="checkbox"/> Vascular lesion <input type="checkbox"/> Other, Specify _____ _____	<b>Head/Neck</b> <input type="checkbox"/> Nasal Cavity (\$740) <input type="checkbox"/> Skull (\$685) <input type="checkbox"/> Bullae (\$660) <input type="checkbox"/> Neck Soft Tissue (\$740)
<b>Limb/Joints</b> (\$660; with comparison) <b>Lesion ~ Left or ~ Right</b> <input type="checkbox"/> Manus <input type="checkbox"/> Pes <input type="checkbox"/> Carpus <input type="checkbox"/> Tarsus <input type="checkbox"/> Antebrachium <input type="checkbox"/> Crus <input type="checkbox"/> Elbow <input type="checkbox"/> Stifle <input type="checkbox"/> Humerus <input type="checkbox"/> Femur <input type="checkbox"/> Shoulder	<b>Other Body Areas</b> <input type="checkbox"/> Abdomen (\$720) <input type="checkbox"/> Thorax (\$720) <input type="checkbox"/> Pelvis (\$660) <input type="checkbox"/> Abdomen and Pelvis (\$945) <input type="checkbox"/> Trauma/Whole Body (\$945)	<b>Other, Specify</b> _____ _____ _____ _____ _____

**Note: The requesting veterinarian is solely responsible to select the appropriate image area. If unsure which image area should be selected, please email or call GatorVetImaging for assistance or visit the website for additional information).**

## Essential Patient History/Medical Condition (include clinical signs, PE findings, key diagnostic test results):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Does the patient have or has the patient had any of the following (if yes, please provide details)

### Essential Details

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cardiac Pacemaker	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Brain Surgery	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shunts, Stents, Filters, or Intravascular Coil	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Orthopedic Pins, Screws, Rods, Joints, Prosthesis	Specify type of metal: _____

Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of Cancer or Tumors	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation or Chemotherapy	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Previous Back Surgery: Cervical, Thoracic, Lumbar	Indicate surgery date and location of implants if used: _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gunshot Wounds	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of Ingesting any Metal Object	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is Animal Micro-Chipped	_____

**Has the patient ever had any problem with the following organ systems or conditions**

			Explanation
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Exercise Intolerance	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chronic Cough	_____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recent change in water consumption or eating habit	_____

**Additional Medical History:**

Yes    No  
        Has the patient ever had an allergy or a reaction to any drug or medication including vaccines?  
If known, what was the medication or vaccine that caused the reaction and when did it occur?

\_\_\_\_\_

Yes    No  
        Has the patient ever had a seizure?

- If yes, when did it occur? \_\_\_\_\_
- How frequently do they occur? \_\_\_\_\_
- If treating medically, what medications? \_\_\_\_\_

~ Diazepam - Dose: \_\_\_\_\_

~ Phenobarbital - Dose: \_\_\_\_\_

~ Potassium Bromide - Dose: \_\_\_\_\_

Yes    No  
        Is the patient currently receiving ANY medications or supplements?  
If yes, what are they, and what is the intended purpose of these substances?

\_\_\_\_\_

**List Previous Surgeries, Anesthetic Agents Used and Complications:**

**Note:** Patients must have a CBC and serum chemistry profile completed within a 2-week window prior to anesthesia. CBC and serum chemistry results must be faxed to GatorVetImaging at (352) 294-9877. Patients will not be anesthetized until the blood work is received and reviewed by the attending anesthesiologist.

I attest that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Veterinarian's Signature

\_\_\_\_\_  
Date

**For GatorVetImaging Staff Use Only**

Today's Weight: \_\_\_\_\_ kgs

**Pulse and Respirations**

- Pulse Rate: \_\_\_\_\_ bpm
- Respiration Rate: \_\_\_\_\_ bpm

Heart Sounds:  
Lung Sounds:

Normal	Abnormal
~	~
~	~

Pertinent Physical Exam Findings:

Notes to Anesthesia:

\_\_\_\_\_  
Admitting Clinician

\_\_\_\_\_  
Date