

GatorVetImaging Small Animal MR 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: _____

MR Image Request: Check Area to be Imaged

(Each box corresponds to one imaging area. Total fee \$1,250 for initial image area, \$570 per additional area; fee includes all costs of anesthesia, exams, and report.)

<p>Spine</p> <p><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</p>	<p>Brain</p> <p><input type="checkbox"/> Brain <input type="checkbox"/> Brain plus C1, C2, Spine</p>	<p>Head/Neck</p> <p><input type="checkbox"/> Nasal Cavity/Sinuses <input type="checkbox"/> Osseous Bullae <input type="checkbox"/> TMJ <input type="checkbox"/> Soft Tissue Neck</p>
<p>Limb/Joints: Note: ~ Left or ~ Right</p> <p><input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Stifle <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Pelvis <input type="checkbox"/> Shoulder</p>	<p>Soft Tissue</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> Thorax</p>	<p>Other, Specify</p> <p>_____ _____ _____ _____ _____</p>

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 No Cardiac Pacemaker _____

Yes No 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 <input type="checkbox"/>	No <input type="checkbox"/>	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 <input type="checkbox"/>	No <input type="checkbox"/>	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?

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

	Normal	Abnormal
Heart Sounds:	~	~
Lung Sounds:	~	~

Pertinent Physical Exam Findings:

Notes to Anesthesia:

Admitting Clinician

Date