

Please fax or email form back to the appointment location.



Fax: 410-630-5576  
Email: annapolis@synergyvip.com  
Email: gaithersburg@synergyvip.com  
Email: vienna@synergyvip.com

**Outpatient Ultrasound Referral Form**

**Referral Partner Information:**

Referring Veterinarian: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Final Report Communication Preference (choose one):

Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Patient Information:**

Client Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Canine  Feline Breed: \_\_\_\_\_

Sex:  M  MN  F  FS DOB/Age: \_\_\_\_\_

Prior imaging related to clinical concern:  Yes  No

└ Digital (DICOM format):  Sent to Synergy  CD

└ Analog:  Sent with owner

**Study Information:**

Study Type:  Abdomen  Thorax (non-cardiac)  Neck  Other: \_\_\_\_\_

Reason for Referral/Primary Complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinical Exam/Pertinent Labwork Findings/Working Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific Questions to be Addressed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The radiologist will contact the referring veterinarian regarding the results of the ultrasound by phone, email, or both. If there are any questions prior to the appointment, please contact Synergy Veterinary Imaging Partners.