



**Radiographic Consultation** David Herring, DVM, DACVR

**DATE:** \_\_\_\_\_

**Referring Veterinarian**

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

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address 2: \_\_\_\_\_

Fax: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Client**

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

**Patient**

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

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

Breed: \_\_\_\_\_ DOB: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs Color: \_\_\_\_\_

Canine  Feline  Other: \_\_\_\_\_

Male  Female

Neutered  Spayed

**History**

Primary Complaint: \_\_\_\_\_

History: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_