



Radiography Consultation Request Form

Clinic: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

DVM: _____ Phone: _____

Patient: _____ Owner: _____

Breed: _____ Age: _____ M MC F FS

History: _____

Tentative Diagnosis: _____

No. of Radiographs: _____ Views: _____ Date Made: _____

PLEASE CHECK ONE:



Phone Report



Phone & Written Report (extra charge)

For VIS use only

Date Received: _____ Payment Received _____ Send Invoice _____

Radiologist: _____

Phone Report:	Date and Time Called	Person Receiving Message
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments: _____