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VETERINARY TEACHING HOSPITAL

RADIOLOGY SECTION

1002 OTT ROAD · PO BOX 647060

PULLMAN, WA 99164-7060

509-335-0711 Fax: 509-335-9432

radiology@vetmed.wsu.edu

FOR OFFICE USE ONLY
REFERRAL NUMBER
DATE RECEIVED
DATE MAILED

PLEASE TYPE OR PRINT CLEARLY

DIAGNOSTIC IMAGING REFERRAL FORM

Referring Veterinarian _____ Phone _____
 Clinic _____ Fax _____
 Street _____ E-mail _____
 City, State/Province, Zip _____
 Previous WSU Patient? No WSU Clinic # _____
 Number of images submitted _____

Please make sure all films have ID markers with animal and clinic names

PATIENT IDENTIFICATION: If resubmission, indicate previous referral number _____
 Patient Name _____ Owner _____
 Species _____ Breed _____ Age _____ Sex _____

PLEASE INDICATE TIMES FOR BARIUM AND IVP STUDIES ON FILMS HISTORY

Date(s) of films: _____

Area(s) radiographed/Area of Concern: