Eastern Iowa
VETERINARY SPECIALTY CENTER

Radiograph Referral Form / Report

EIVSC use

Date rcvd: _____
# of films / size: _____
# of films / size: _____
# of films / size: _____
Checked in by: _____

REFERRING HOSPITAL

Referring veterinarian: _____ Date : _____ # of films: _____

Hospital name: _____ Phone: _____ Fax: _____

Patient name: _____ Client name: _____

Species: _____ Breed: _____ Sex: _____ Age: _____

Pertinent clinical history (use back if necessary):

EASTERN IOWA VETERINARY SPECIALTY CENTER **(Please do not write below this point, for EIVSC use only.)**

Radiographic findings:

Thank you for this referral. If I can be of further assistance, please do not hesitate to call.

Sincerely,

_____ _____
Date

Faxed to RDVM
Date: _____
Time: _____
By: _____
❒ billed
❒ do not bill
per _____

❒ Films are being held at Eastern Iowa Veterinary Specialty Center

755 Capital Drive SW, Cedar Rapids, IA 52404 (319) 841-5161 fax (319) 841-5160