



# RADIOGRAPH INTERPRETATION REQUEST

DATE SENT: \_\_\_\_\_

Doctor: \_\_\_\_\_  
Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_  
FAX: (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Client Name: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Species: \_\_\_\_\_  
Breed: \_\_\_\_\_  
Age / Birth date: \_\_\_\_\_  
M MN F FS  
Weight: \_\_\_\_\_ kgs / lbs BCS \_\_\_\_\_ /9

**Please indicate below to whom these films should be routed:**

- Radiologist - Dr. Brett Kantrowitz / Dr. Jason Francis: Written Report: (\$80 Fee Enclosed)
- Internal Medicine – Attention: \_\_\_\_\_: Courtesy Interpretation (Please Enclose Return Postage)
- Oncology – Attention: \_\_\_\_\_: Courtesy Interpretation (Please Enclose Return Postage)
- Surgery – Attention: \_\_\_\_\_: Courtesy Interpretation (Please Enclose Return Postage)
- Critical Care – Attention: \_\_\_\_\_: Courtesy Interpretation (Please Enclose Return Postage)

**Please include a brief history, summary of your clinical findings, and reason for taking the radiographs.**

**VMSG USE ONLY: V0607**

Date Received: \_\_\_\_\_ By: \_\_\_\_\_ Routed to Dr: \_\_\_\_\_ Date Returned: \_\_\_\_\_ Method: \_\_\_\_\_ By: \_\_\_\_\_