



Referral for Outpatient Computed Tomography (CT)

Please fast your pet from 10 pm the night before the appointment unless directed otherwise.

Date: _____ Requested Scan Date: _____

Referring Veterinarian: _____ Referring Clinic/Hospital: _____

Owner Details: Name: _____
Address: _____
Suburb: _____
Postcode: _____

Patient Details: Name: _____
Breed: _____ Sex: _____
Colour: _____ Age: _____

Has patient visit SAEC/ SARC previously? **YES / NO**

Patient History: _____

Presumptive Diagnosis: _____

Area(s) to be scanned: _____

Is contrast required? **YES / NO / UNKNOWN**

Has a pre anaesthetic screen been performed? **YES / NO.**

If no, would you like this to be done prior to anaesthesia at **\$137.50** inc GST? **YES / NO**

Does this patient have any known medical conditions that may affect anaesthesia? **YES / NO.**

Please specify _____

Is this patient on any current medications? **YES / NO .**

Please specify _____

Correspondence

Do you wish the *Southern Animal Referral Centre* to contact owners with results? **YES / NO**

Veterinarian Signature: _____

PLEASE ENSURE THIS FORM IS COMPLETED AND SIGNED. FORMS SHOULD BE FAXED TO SARC ON 03 9532 5262 AT LEAST 24 HRS BEFORE THE SCHEDULED APPOINTMENT FOR THE SCAN.

Once we receive this form we will call you to finalise an appointment time. All admissions are between 8am and 11am unless otherwise agreed.

Southern Animal Referral Centre
248 Wickham Rd. Highett VIC 3190 **Melways ref 77 H-8**
enquiries@sarc.com.au
Phone: 03 9532 5261 FAX: 03 9532 5262

