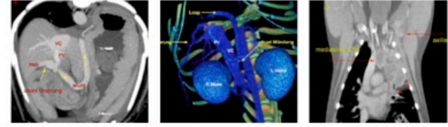
SonoPath

CT Services @ Blairstown Animal Hospital



FOR EDUCATIONAL TELERADIOLOGY SERVICES
UPLOAD AT SonoPath.com 1-800-838-4268

FOR ON SITE CT IN NJ, NY & PA
To schedule an appt. call: 1-908-362-6430
29 Cedar Lake Road, Blairstown, NJ 07825

Referring Hospital: ______________________________ **Referring Doctor:** ______________________________

Hospital Email for CT Report Notifications: ____

Patient First Name: ____________________ **Last Name:** __________________ **Species:** K9 FEL Other________

Age: ____________________ **Breed:** ____________________ **Weight:** ____________________ **Sex:** M MN F FS

Reason for CT/Notes:____

____

Current Meds: ____

CBC/Chem/ UA Findings: ____

Other Diagnostic Imaging/Procedures Completed (Please Include Reports When Submitting Referral):

RAD: YES / NO Date: __________ **U/S:** YES / NO Date: __________ **FNA/Biopsy:** YES / NO Date: __________

FOR REFERRING DOCTOR:

SonoPath has a strict agreement with Blairstown AH to maintain the professional relationship that works best for your hospital. These procedures will be respected, however if a medical crisis occurs, the focus will be on saving the patient.

Please select the method of communication you prefer for this case:

___ No communication with Blairstown Animal Hospital

___ No communication with Blairstown Animal Hospital unless an emergency medical procedure needs to be performed

___ Blairstown Animal Hospital staff should call when patient arrives and when the scan is completed

Signature: ______________________________ **Date:** ______________

Phone Number You Can Be Reached: ______________________________

**A copy of the CT report will be uploaded to your SonoPath reports portal. Add additional email you'd like report sent to: ______________________________

NOTATE CAVITY TO BE IMAGED:

___ Head
___ Dental Only
___ Thorax
___ Abdomen
___ Abdomen Portosystemic Shunt
___ Abdomen Ectopic Ureter
___ Pelvic Cavity
___ Elbows
___ Shoulders
___ Pelvis
___ Stifles
___ Neck (Soft Tissue)
___ Spine - Entire
___ Spine - Cervical
___ Spine - T3-L3
___ Spine - L3-S4
___ Other (Please Specify Below)

____

Ready to Submit?

Please **FAX** (908-362-8726) or **EMAIL** (VCABlairstown@VCA.com) **the following documents:**

- Full Exam/Medical History Sheet
- Signed and Completed Referral Form
- Blood Work - ***If blood work has not been done, Blairstown AH can do it the day of appointment for $118 extra***
- Supporting Reports from Other Diagnostic Imaging/Procedures