



## ANIMAL SPECIALTY CENTER IMAGING REQUEST FORM

Animal Specialty Center  
9 Odell Plaza  
Yonkers, NY 10701  
Ph 914-457-4000  
Fx 914-457-4001

Please fill out ONE form per patient and fax to Referral Case Coordinator at 914-457-4001

Request for: Abdominal Ultrasound

Date of request:

Name of hospital:

Requesting DVM:

Telephone:

Email:

### PATIENT INFORMATION

Client name:

Pet name:

Species: Breed:

Sex: Age: Weight:

Current medications and doses:

Brief case synopsis/reason for referral:

For internal use only (please do not write below this line)

*Called back*

*Scheduled for*

*Initials*

*DVM Assigned*

*Added to schedule*