

Date _____



Imaging Interpretation Request

Films [] Disc [] Digital Images [] Vetpacs code _____

Referral Information

Veterinarian _____ Clinic _____

Phone _____ Fax _____

Email _____

Client Information

Client name (last, first) _____

Patient Information

Patient Name _____ Has patient previously visited SFVS? []yes []no

Age _____ Sex/Neutered _____ Weight _____ Breed _____

History and Physical Exam Findings

Area(s) imaged/date(s) taken _____

Chief complaint or working diagnosis _____

History _____

Physical Findings/Diagnostic tests performed _____

Treatments for current problem _____

Specific questions about films sent _____

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Pricing: Review of Radiographs with a faxed report: \$58.00
Review of CT/MRI with a faxed report: \$150.00
Please ensure that all images sent to SFACC are labeled with patient name and hospital name. Retain copies of your disc files, since discs will not be returned to your practice.