



Radioiodine Referral Form

Date: _____

Referring Veterinarian: _____ Referring Hospital: _____

Phone: _____ Fax: _____ E-mail: _____

Client Name: _____
Last First

Home Phone: _____ Work Phone: _____ Cell/After hours emerg#: _____

Patient information

Name: _____ Age: _____ Sex: _____ Spayed/Neutered: Y N

Breed: _____ Color: _____ Weight: _____

History:

Comments:

Other:

- Tapazole trial performed as described in the VICSD Radioiodine Referral Guidelines and Checklist
- Ancillary labwork performed and submitted as described in the VICSD Radioiodine Referral Guidelines and Checklist

Office use only

Appointment date _____ Appointment Time _____