



Portland
Veterinary Specialists

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Radiograph Consultation Form

Referring Veterinarian: _____
Hospital/Clinic: _____
Phone: _____
Fax: _____
Date: _____

Client Information
Name: _____
Address: _____
City: _____ St: _____ Zip: _____

Patient Information
Name: _____ Age: _____
Species: _____ Breed: _____
Sex: M MN F FS Color: _____

Chief Concern: _____

History: _____

Special Comments/Requests: _____



Consultation Report

Date: _____

Views available for review: _____

Findings: _____

Recommendations: _____

Faxed: