



Clinic/Animal Hospital: _____

Requesting Doctor: _____

Phone Number: _____ Fax Number: _____

Physical Address: _____

Owner Last Name: _____ Pet Name: _____

Owner First Name: _____ Patient ID: _____

Species: _____ Breed: _____

Age: _____ Weight: _____ Sex: M MN F FS Unknown
(circle one)

Exam Type: _____ Exam Date: _____

Number of X-rays submitted: _____

Patient was anesthetized during x-ray acquisition: Y N
(circle one)

Views (please check/circle all that apply):

- | | | | |
|----------------------------------|--|--|--|
| <input type="checkbox"/> Skull | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Carpus (R or L) | <input type="checkbox"/> Tarsus (R or L) |
| <input type="checkbox"/> C-Spine | <input type="checkbox"/> Sinus | <input type="checkbox"/> Forepaw (R or L) | <input type="checkbox"/> Hindpaw (R or L) |
| <input type="checkbox"/> T-Spine | <input type="checkbox"/> Shoulder (R or L) | <input type="checkbox"/> Hip (R or L) | <input type="checkbox"/> Soft Tissue Neck |
| <input type="checkbox"/> L-Spine | <input type="checkbox"/> Humerus (R or L) | <input type="checkbox"/> Femur (R or L) | <input type="checkbox"/> Fetlock (R or L) |
| <input type="checkbox"/> Thorax | <input type="checkbox"/> Elbow (R or L) | <input type="checkbox"/> Stifle (R or L) | <input type="checkbox"/> Distal Extremity |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Antebrachium (R or L) | <input type="checkbox"/> Tibia/Fibula (R or L) | <input type="checkbox"/> Other Exam: _____ |

Relevant Health History/Notes: _____

Attach additional pages for notes as needed.

Mail Requests To:

PetRays Veterinary Telemedicine Consultants
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