MOCHDRE
veterinary practice

CT Referral Request Form

Client details	**Referring Vets details**
Title: _____	Surgeon name: _____
First Name:_____	Practice name:_____
Surname: _____	Practice Address:
Address:	_____
_____	_____
_____	_____
_____	_____
Postcode: _____	_____
Tel number: _____	Postcode: _____
Mobile: _____	**Tel number:** _____
Email: _____	Email: _____

Name:	**Species:**	**Breed:**	**Age/DOB:**
Gender: M/F E/N	**Colour:**	**Insured: Y/N**	**Company:**

Brief history (inc any medications currently taking)/questions to be answered (continue over if req)

Scan areas required (please tick):

Head ☐ Thorax☐ Abdomen ☐ Shoulder ☐ Elbow ☐ Stifle ☐

Tarsus☐ Carpus☐ Pelvis/tail ☐ Neck C1-T2 ☐ Spine T3-L7/S1 ☐

Response time:

48hrs (2 business days) ☐ 4hr (+£250) ☐

PLEASE REMEMBER TO ATTACH FULL CLINICAL HISTORY WITH THIS FORM

PLEASE INFORM OWNER DIRECT INSURANCE CLAIMS ARE NOT OFFERED UNLESS BY PRE-AUTHORISATION OR PRIOR AGREEMENT

By submitting this form I confirm that the information of the individual concerned has given full permission for the transfer of personal details to Mochdre Vets

Williams House, Conway Road, Mochdre, LL28 5HE
Contact - info@mochdrevets.co.uk Tel: 01492 546112