RIVERVIEW ANIMAL HOSPITAL

24 Hour Emergency Care

# Referral Form for Radio-Iodine Therapy

Owner _____ Patient _____

Breed _____ Age _____ Sex FS MN F M

Owner contact number(s) _____

Referring Hospital _____

Referring Veterinarian _____ Contact # _____

History: Please include any adverse drug reactions, previous illness or surgery

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Current treatments and response to therapy (please attach all pertinent lab results)

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Any additional comments:

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