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Referral Form for Radio-Iodine Therapy

Owner's Name: _____ Patient's Name: _____

Breed: _____ Age: _____ Sex: F M Spayed/Neutered

Owner's Contact Details: _____

Referral Hospital: _____

Referring Veterinarian: _____ Contact Number: _____

Patient History – Include any adverse drug reactions, previous illness, or surgery.

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

Any additional comments:
