RADCATS®

REFERRAL for RADIOACTIVE IODINE TREATMENT

The Animal Hospital of Carrboro
112 W. Main St, Carrboro, NC 27510
(919) 967-9261 (919) 929-5719 radcat131@gmail.com

Client Name_____ Patient_____ Age_____

Client Phone Number_____ Client Email_____

Referring DVM_____ Hospital_____

Hospital Address_____

Clinic Phone Number_____ Clinic Email_____

NOTE: All cats referred must be current on vaccines to receive treatment.
FVRCP must be current within the past three years. Rabies must be current per state rabies laws.

FVRCP last date given:_____ Rabies last date given:_____

INITIAL DIAGNOSIS DATE:_____ HIGHEST MEASURED T-4_____
Please send absolute value. No "Greater-than" Values.

Body Condition	Normal ☐	Thin ☐	Very Thin ☐	
Heart Rate and Rhythm	Normal ☐	Abnormal ☐	Murmur Present ☐	Grade ____/IV
Renal Disease	None ☐	Mild ☐	Moderate ☐	Severe ☐
Thyroid Mass Present	YES ☐ NO ☐	If Yes, what size (CM) is the mass? Right side _____	Left side _____	

Is this patient on any medication(s)? Please list medication and dosage:_____

REQUIRED DIAGNOSTICS: CBC/Chemistry Panel/T-4 _____ Urinalysis _____ Both should be current within last 30 days

Optional Diagnostics: Chest X-rays ____ ECG_____ Echo_____ Blood Pressure ____ Other
These diagnostics should be based on condition of pet.

Recent Illness or Injuries that were medically or surgically managed:_____

PLEASE RETURN THIS REFERRAL INFORMATION AND FAX/EMAIL LAB RESULTS TO US 7 DAYS PRIOR TO TREATMENT