

# Request for CT

Date: \_\_\_\_\_

Client: \_\_\_\_\_

Hospital: \_\_\_\_\_

Patient: \_\_\_\_\_

Dr. \_\_\_\_\_

Species: K-9 Feline Other

Phone: \_\_\_\_\_

Breed: \_\_\_\_\_

Fax: \_\_\_\_\_

Sex: F FS M MC

Age: \_\_\_\_\_

Years Months Weeks

Clinical Signs:

Please send radiographs/request to:  
Jeff Siems, MS, DVM, DACVR  
Inland Empire Veterinary Imaging  
21 East Mission  
Spokane, WA 99202  
Phone: 509-326-3427  
Fax: 509-326-7213