

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
Sammy Ramirez, DVM, MS, DACVIM, DACVR
Inland Empire Veterinary Imaging
21 East Mission
Spokane, WA 99202
Phone 509-326-3427
Fax 509-326-7213