

**WESTERN COLLEGE OF VETERINARY MEDICINE**

Fax 306-966-1639 Phone 306-966-1894

**RADIATION ONCOLOGY REFERRAL FORM**

Referring Veterinarian
Name _____
Phone _____
Fax _____
E-mail _____
Hospital Name _____
Hospital Address _____
_____
_____

Patient Information
Client Name and Address _____
_____
_____
Patient name _____
Species _____ Breed _____
DOB _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> NM <input type="checkbox"/> NF
Weight (kg) _____ Colour _____
Client Phone (home) _____
Client Phone <input type="checkbox"/> work <input type="checkbox"/> cell _____
Client E-mail _____

Date of initial presentation for tumour \_\_\_\_\_

Tumour Type \_\_\_\_\_  
(PDS lab number if available)

Tumour diagnosis based on:  Cytology

Gross Disease  Microscopic Disease

Histopathology  Radiology

Has the tumour been surgically resected prior to referral?  Yes  No

Date(s) of previous surgical resection(s) \_\_\_\_\_

Tumour Size \_\_\_\_\_ cm x \_\_\_\_\_ cm x \_\_\_\_\_ cm  
(if surgically resected please indicate size prior to resection)

Tumour Location \_\_\_\_\_

**STAGING COMPLETED PRIOR TO REFERRAL TO WCVM**

Please check if performed:

- Tumour biopsy/histopathology
- CBC, blood chemistry
- Urinalysis
- FeLV/FIV/T4 (feline)
- Chest radiographs (3 views)
- Abdominal ultrasound
- Bone Marrow Aspirate
- Regional Lymph Node Aspirate or Biopsy
- Other

Date of Test/Abnormal Findings

\_\_\_\_\_ PDS# \_\_\_\_\_

\_\_\_\_\_

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**\*\*PLEASE SEND ALL LABORATORY RESULTS AND INCLUDE HARD COPIES OF IMAGING\*\***

**Medical Conditions**

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Date of Diagnosis

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**Current Medications/Supplements**

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Dose and Frequency of Administration

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**Previous Surgeries (non-tumour-related)**

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Date of Surgery

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**Patient Allergies**

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Does patient have any metal implants?       Yes       No       Unknown  
If yes, location of implant \_\_\_\_\_

**Current Diet** (please include amount and frequency of meals if relevant)

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**Special Care Required**

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**Veterinarian's Preferred Method(s) of Contact**       Phone       Email       Fax

Our radiation staff may call your clinic to discuss this referral further and to obtain additional information if needed. If convenient, please indicate the contact person who can best assist with this referral: \_\_\_\_\_

If you have any questions about a referral case please contact Radiation Oncology at 306-966-1894 or visit our website at [www.petradtherapy.usask.ca](http://www.petradtherapy.usask.ca)

**Next Step: (Please check one)**

- Client will call Radiation Oncology      [   ]
- Radiation Oncology to call our clinic      [   ]
- Radiation Oncology to call client      [   ]