RADCATS®

REFERRAL for RADIOACTIVE IODINE TREATMENT

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

Client Name_____Patient_____Age_____
Client Phone Number_____ Client Alternate Phone_____

Referring DVM_____ Hospital_____
Hospital Address_____
Clinic Phone Number_____ Clinic Alternate Phone_____

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

INITIAL DIAGNOSIS DATE:_____ HIGHEST MEASURED T-4:_____
Please send Absolute T-4 value- No "Greater –Than" Vaules.

Body Condition Normal ☐ Thin ☐ Very Thin ☐

Heart Rate and Rhythm Normal ☐ Abnormal ☐ Murmur Present ☐ Grade ____/VI

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? 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 LAB RESULTS TO US 7 DAYS PRIOR TO TREATMENT