SOUTH CAROLINA
VETERINARY SPECIALISTS
& EMERGENCY CARE
State of the Art Care, in the Heart of the State

REFERRAL for RADIOACTIVE IODINE TREATMENT

Client Name: _____ Patient: _____ Age: _____

Referring D.V.M.: _____ Client Phone: _____

Clinic name/address: _____
(Include City, State, & Zip Code)

Physical Exam Findings

System	Normal	Abnormal	Comments
Heart Rate & Rhythm			
Murmurs (___/VI)			
Thyroid Mass			

*Has the pet been off Tapazole®/Mathimazole® for 7-10 days prior to T-4?*_____
Dosage- _____ Duration- _____

Check List for Diagnostics Enclosed (
Please be aware all Blood work/Radiographs should be within 30days):

- ☐ All medical records & progress reports
- ☐ CBC/Chemistry profile
- ☐ Urinalysis
- ☐ T4 (Antech)
- ☐ Chest Radiographs

Optional Diagnostics depending on condition of patient:

- ☐ EKG
- ☐ Cardiac Ultrasound
- ☐ Blood Pressure

Presented for (chief complaint):_____
_____
_____

In the event other abnormalities are detected we will suggest further diagnostics to determine possible complications or disease process that may preclude treatment. If the client desires, we will return the patient to you for further work up. Should the client request clinicians at the hospital to perform further diagnostic tests, we will send you a copy of the test results at discharge.
PLEASE HAVE THIS REFERRAL INFORMATION TO US 7 DAYS BEFORE TREATMENT.

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