



Robert Cole, DVM
Diplomate:
American College Veterinary Radiology

REQUEST FOR FLUOROSCOPIC EXAM

Please include any current lab work, radiographs and medical record

Owner's Last Name _____

Animal's Name _____

Sex: M F Neutered: Yes No

Species/Breed: _____

Age: _____

Your Contact Information:

Clinic Name: _____

Phone () _____

FAX: () _____

Veterinarian: _____

Address: _____

City/State/Zip Code _____

Preferences:

Faxed/Typed Report Only _____

Phone Call plus Faxed/Typed Report _____

Case History/Comments or Additional Instructions:

Please use this form and send radiographs by mail or deliver to:

Robert Cole, DVM, DACVR
Animal Imaging
6112 Riverside Drive Irving, TX 75039
972.869.2180 972.869.9916