MEDVET
Leading Specialty Healthcare for Pets

Radioactive Iodine Treatment Referral Form

Date: _____

Referral Partner Information

Referring Veterinarian: _____ **Clinic/Practice Name:** _____

Phone: (_____) _____

Patient Information

Client Name: _____ **Phone:** (_____) _____

Patient Name: _____ ☐ **Feline**

Breed: _____ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age:** _____

Referral Practice

☐ MedVet Cincinnati ☐ MedVet Columbus

Clinical Data at Diagnosis of Hyperthyroidism:

Date: _____

Weight: _____

Total T4: _____

Appetite: ☐ Voracious ☐ Moderate ☐ Poor

BUN: _____

Creatinine: _____

Phosphorus: _____

Urine Specific Gravity: _____

(if available)

Clinical Data at Diagnosis of Hyperthyroidism:

Date: _____

Weight: _____

Total T4: _____

Methimazole Dose:

Treatment Duration:

Route: ☐ Oral ☐ Transdermal

Appetite: ☐ Voracious ☐ Moderate ☐ Poor

BUN: _____

Creatinine: _____

Phosphorus: _____

Urine Specific Gravity: _____

(if available)

Our Locations:

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