

**RADCATS®**

**REFERRAL for RADIOACTIVE IODINE TREATMENT**

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

Client Name \_\_\_\_\_ Patient \_\_\_\_\_ Age \_\_\_\_\_

Referring D.V.M. \_\_\_\_\_ Hospital \_\_\_\_\_

Hospital Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**NOTE: All referred cats 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: \_\_\_\_\_ INITIAL DIAGNOSTIC T4: \_\_\_\_\_  
 (Reference lab value, not in-house)**

**NOTE: PLEASE SEND ABSOLUTE VALUE - NO "GREATER-THAN" VALUES.**  
 Please do not send T-4 values taken while pet is on Tapazole® or Methimazole. If cat is currently on these medications, we may need the T4 re-taken when the cat is off medication for two weeks.

<b>Body Condition</b>	Normal	<input type="checkbox"/>	Thin	<input type="checkbox"/>	Very Thin	<input type="checkbox"/>		
<b>Heart Rate and Rhythm</b>	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>	<b>Comments:</b>			
<b>Murmurs ( )/VI</b>								
<b>Renal Disease</b>	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
<b>Comments:</b>								
<b>Tumor Size: If both thyroid glands are enlarged, add sizes for reported size.</b>								
	<1.0 X 0.5 cm.	1.0 X 0.5 cm. to 3.0 X 1.0 cm.			> 3.0 X 1.0 cm.			
<b>Right</b>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
<b>Left</b>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			

**Is this patient on any medication? Please list medication and dosage.**

\_\_\_\_\_

**Please Note: Bloodwork must be current within 30 days of treatment date.**

**Check required diagnostics enclosed: CBC/Chemistry Panel/T4  Urinalysis**

**OPTIONAL DIAGNOSTICS- depending on condition of patient:**

**Chest Radiographs  ECG  Cardiac Ultrasound  Blood Pressure  Other**

**If other abnormalities are detected we may suggest further diagnostics.  
 Should the client request that the tests be done at this facility, we will send copies of test results.  
 PLEASE HAVE THIS REFERRAL INFORMATION TO US 7 DAYS BEFORE TREATMENT.**