

CATT Clinic
Coastal Area Thyroid Treatment Clinic
A Division of College Road Animal Hospital, PLLC

Referral Form

Referring Veterinarian _____
Referring Animal Hospital _____
Hospital Telephone Number _____
Hospital Fax Number _____
Client's Name _____
Client Contact Number _____
Cat's Name _____ DOB _____ Sex _____ Breed _____
Indoor/Outdoor _____

Vaccine Due Dates:

FVRCP _____ Rabies _____ Feleuk _____

Patient must have a CBC/Chemistry completed within the past 60 days and Urinalysis completed within the past 30 days. Pet must have a T4 level completed no less than 7 days after discontinuing Methimazole/Tapazole

CBC/Chemistry Date _____
Urinalysis Date _____
Initial T4 Date _____ Result _____
T4 (after discontinuing Methimazole) Date _____ Result _____

* Please submit T4 results from a reference lab, not an in-house test

Thyroid Nodule (if present, size, location) _____

Methimazole Dose (if applicable) _____

Remarkable Exam Findings/Concurrent Disease

Has the pet ever needed sedation for routine procedures (i.e. exam, vaccines)

Yes () No ()

If yes, please explain.

Please attach all laboratory results

Fax 910-392-3126