NORTH WEST NUCLEAR MEDICINE FOR ANIMALS

Today's Date:_____

Referring Clinic:_____ **Referring Doctor:**_____

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

Client Email:_____ **City:**_____ **Postal Code:**_____

Client Address:_____

Patient Name:_____ **Breed:**_____ **Colour:**_____

Sex: **MN** ◉ **FS** ○ **Age:**_____yrs

Parameters below should be from the date of hyperthyroid diagnosis	
Date of diagnosis:_____	
Starting T4:_____nmo/L	**cTSH:** (if applicable)_____ng/ml
Creatinine:_____umo/L	**SDMA:**_____ug/dL
Potassium:_____mmol/L	**Weight:**_____kg

***If we require additional diagnostics on your patient we will contact your clinic directly.**

Please check off the following symptoms your patient is displaying:	**Is your patient currently on Methimazole?** **Yes** ○ **No** ◉
PU/PD Weight Loss/muscle Wasting Vomiting/diarrhea Tachycardia (>210bpm) Tachypnea Polyphagia Other:_____	**If yes, have they exhibited any of the following?** Pruritus/Excoriations Neutropenia/Leukopenia on CBC Vomiting/diarrhea Hyporexia Other:_____ *Please note most side effects occur roughly 2 weeks after starting methimazole or increasing the dose.

Does your patient have any comorbidities? Are they currently on any medication? Please describe:

_____

_____

_____

_____

***The referral will only be processed once all patient information has been received.**
Please attach all blood work and medical records from the date of diagnosis up until today's date.