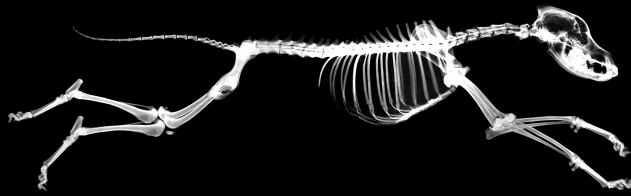


COLORADO CANINE ORTHOPEDICS



VETERINARY SPECIALTY CENTER

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RADIOGRAPH REVIEW

Referring Hospital: _____

Referring Veterinarian: _____

Clinic Phone Number: () _____ Fax: () _____

Client's Name: _____

Pet's Name: _____ Breed: _____

Age: _____ Gender: _____

Tentative Diagnosis: _____

Radiographs Enclosed: _____

Brief History: _____

Special Concerns: _____

