**REQUISIÇÃO DE EXAMES**

NOME DO PACIENTE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RAÇA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEXO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ESPÉCIE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IDADE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PESO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOME DO TUTOR RESPONSÁVEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEFONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENDEREÇO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MÉDICO VETERINÁRIO RESPONSÁVEL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRMV:\_\_\_\_\_\_\_\_ TELEFONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLÍNICA : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTÓRICO CLÍNICO**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SUSPEITA CLÍNICA:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **RADIOGRAFIA SIMPLES:**

TORÁX ( ), ABDÔMEN ( ), PELVE ( ) E PESCOÇO ( ).

CRÂNIO\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ATM ( ) MANDÍBULA ( ) MAXILA ( ) BULHAS TIMPÂNICAS ( ) SEIOS NASAIS ( ) CALOTA CRANIANA ( )

COLUNA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CERVICAL ( ) CERVICOTORÁCICA ( ) TORÁCICA ( ) TORACOLOMBAR ( ) LOMBAR ( )

LOMBOSSACRA ( ) CAUDAL ( )

MEMBRO TORÁCICO: ESQUERDO ( ) DIREITO ( ) ESCÁPULA ( ) OMBRO ( ) ÚMERO ( ) COTOVELO ( ) RÁDIO E ULNA ( ) CARPO ( ) DÍGITOS ( )

MEMBRO PÉLVICO: ESQUERDO ( ) DIREITO ( ) COXOFEMORAL ( ) FÊMUR ( ) JOELHO ( ) TÍBIA E FÍBULA ( ) TARSO ( ) DÍGITOS ( )

\*PACIENTE NECESSITA SEDAÇÃO OU ANESTESIA GERAL PARA REALIZAÇÃO DO EXAME ( )

**RADIOGRAFIAS CONTRASTADAS:**

EXAME: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ULTRASSONOGRAFIA:**

ABDOMINAL ( ) GESTACIONAL ( )

**PROCEDIMENTOS GUIADOS**

CISTOCENTESE ( ) ABDOMINOCENTESE ( )

TORACOCENTESE ( ) CITOLOGIA ECOGUIADA ( )

**CARDIOLOGIA**

ECOCARDIOGRAMA ( ) ELETROCARDIOGRAMA ( )

CONSULTA AVALIAÇÃO ( ) PRÉ ANESTÉSICA ( ) PRESSÃO ARTERIAL ( )

**ENDOSCOPIA**

ENDOSCOPIA DIGESTIVA ALTA ( ) COLONOSCOPIA ( )

BIOPSIA GASTRICA REMOÇÃO DE CORPO ESTRANHO ( )

 ESOFAGICO REMOÇÃO DE CORPO ESTRANHO GÁSTRICO ( )

 Data e Assinatura do médico responsável