Centers
For The Treatment of
Feline Hyperthyroidism
Toll Free (866) 467-TCAT (8228)
FAX (631) 467-3946
www.ThyroCat.com

PATIENT MEDICAL RECORD REQUEST FORM

Veterinarian Information:

Name: _____

Hospital: _____

Address: _____

_____

Telephone: (_____)_____

Fax: (_____)_____

Patient Information:

Client name: _____

Address: _____

_____

Telephone: (_____)_____

Patient name: _____

Age: ____Yrs. Breed: _____ Sex: M MN F FS

Your input is very vital in the final decision to proceed with therapy. If the provided information indicates health-related problems that may preclude or complicate therapy, you, the referring veterinarian will be contacted to discuss these issues.

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION: By (CHECK THE APPROPRIATE BOX FOR EACH REQUEST)

PATIENT MEDICAL STATUS FORM:
( ) ENCLOSED

COPIES OF (within the last 3 months): SUPERCHEM/CBC ( ) ENCLOSED T4 ( ) ENCLOSED
T4 –off Tapazole at least 7 days (if currently on medication) ( ) ENCLOSED ( ) WILL FAX

URINALYSIS ( ) ENCLOSED

RADIOGRAPHS OBTAINED IN THE LAST THREE MONTHS (***Chest DV and Lat are required***):
( ) ENCLOSED

COPY OF ANY ULTRASOUND REPORTS WITHIN THE LAST SIX MONTHS:
( ) ENCLOSED ( ) NOT AVAILABLE

EKG REPORTS WITHIN THE LAST SIX MONTHS:
( ) ENCLOSED ( ) NOT AVAILABLE

Thank you for using Thyro-Cat. If you have any questions concerning the above requested information, please call us.

Thyro-Cat, LLP

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CLIENT:_____ **PATIENT:**_____
HOSPITAL:_____**VETERINARIAN:**_____

THE FOLLOWING INFORMATION IS REQUESTED TO AID IN PLANNING I-131 TREATMENT FOR THIS PATIENT. PLEASE INCLUDE ANY ADDITIONAL INFORMATION THAT YOU FEEL MAY BE RELEVANT FOR THE PRE-TREATMENT ASSESSMENT OF THIS PATIENT.

MEDICAL HISTORY:

1. **EVIDENCE OF RENAL DISEASE/FAILURE? YES ☐ NO ☐**
2. **EVIDENCE OF HEART DISEASE/FAILURE? YES ☐ NO ☐**
3. **OTHER MEDICAL PROBLEMS:**_____
   _____
4. **DOES THE CAT HAVE A CHRONIC HISTORY OF ANY OF THE FOLLOWING DISORDERS: (IF YES, PLEASE EXPLAIN ON REVERSE SIDE OR A SEPARATE SHEET OF PAPER)**
   - ☐ **UPPER RESPIRATORY**
   - ☐ **ASTHMA/PULMONARY DISEASE**
   - ☐ **GASTROINTESTINAL DISEASE**
   - ☐ **URINARY TRACT DISORDERS**
   - ☐ **CHRONIC RENAL FAILURE**
   - ☐ **OTHER ENDOCRINOPATHY**
5. **OTHER CHRONIC PROBLEMS OF CONCERN:**_____
   _____

PREVIOUS TREATMENT FOR HYPERTHYROIDISM:

1. **PREVIOUS TREATMENT: METHIMAZOLE ☐ PREVIOUS I-131 ☐**
   OTHER:_____
2. **HAS THE CAT RECEIVED METHIMAZOLE? YES ☐ NO ☐**
3. **WAS EUTHYROIDISM ACHIEVED WHILE THE CAT WAS RECEIVING METHIMAZOLE?**
4. **RENAL FUNCTION WHILE THE CAT WAS EUTHYROID: DATE**_____
   BUN_____ **CREATININE**_____ **URINE SPECIFIC GRAVITY** _____
   T4_____**OTHER:**_____
   NOT ASSESSED ☐
5. **EVIDENCE OF ADVERSE DRUG REACTION? YES ☐ NO ☐**

DURING TREATMENT AND ISOLATION:

1. **MEDICATION REQUIRED DURING TREATMENT PERIOD? YES ☐ NO ☐**
   (IF YES, PLEASE INCLUDE PRESCRIPTION INFORMATION FOR EACH DRUG)
2. **IS THE CAT IN GOOD OVERALL HEALTH AND IN STABLE CONDITION? YES ☐ NO ☐**