

Referral Form

Date _____

Referring Doctor _____ Phone () _____

Hospital Name _____ Fax () _____

Hospital Address _____

Best time/Day to call _____

Owner's Name _____ Phone () _____

Address _____

Pet's Name _____ Breed _____ Age _____ Sex _____ Weight _____

Presenting Problem _____

History _____

Diagnostic tests performed (Please include date and results) _____

Treatments/Medication (please include dates if possible) _____

Response to therapy _____

***IF DOG IS DIABETIC:** Is Diabetes Controlled? _____ When first diagnosed? _____

Insulin Type: _____ Dose: _____

Assessment of Anesthetic Risk (circle one): LOW MED HIGH

Additional Comments _____

Please include radiographs, copies of laboratory tests and a summary of the medical record. Referral information may be mailed, sent with the client, or sent via fax. If using the mail, please allow enough time for the information to arrive so it is available at the time of the consultation. Phone consults are welcome.

Please have the client call to make an appointment.