IOWA VETERINARY SPECIALTIES
24/7 EMERGENCY HOSPITAL
www.ivsdsm.com

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▪ Emergency ▪ Exotics ▪ Surgery ▪ Acupuncture & Palliative Care ▪

Referring Veterinarian_____ **Date**_____

Hospital_____**Phone**_____ **Fax**_____

Client Name_____ **Home**_____ **Cell**_____

Address _____ **City/Zip** _____

Patient Name_____ **Species**_____

Known Allergies_____

Breed_____**Color**_____ **Sex**_____ **Age**_____ **Weight**_____

Disposition_____ **Radiographs taken: Y or N If yes, please e-mail to rads@ivsdsm.com**

Brief Medical History (past and current):

_____

_____

_____

_____

Reason for referral: _____

Diagnosis or Tentative Diagnosis: _____ ____

Present Medication(s): _____

Requested procedures, therapies, frequency of medication, observations, etc:

_____

_____

Referring Veterinarian's Signature_____

***Please e-mail or fax this referral along with any lab work performed and send radiographs with client. Radiographs will be returned by client.**

It is our pleasure to work in conjunction with you for continued care of your clients. We will remain in touch with you concerning their care. Please let us know if we can further assist you in any way.