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Surgery • Internal Medicine • Emergency & Critical Care • Dermatology • Oncology

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 E-mailed or sent with client: \_\_\_\_\_

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 return 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*