Referral Form

Please send a completed referral form along with copies of radiographs, all lab work, ECG's and other <u>pertinent</u> medical records at the time of the appointment. Records may also be faxed to (541) 282-7999

Please Indicate which service you are referring your client

- ☐ Emergency/Critical care
- ☐ Internal Medicine
- ☐ Surgery
- ☐ Dermatology
- ☐ Oncology

Please note: radiology referral use a radiology referral Form.

Requesting Clinic Information:

Doctor ____________________ Hospital ____________________

Phone ____________________ Street Address ____________________

Fax ____________________ City __________ State ______ Zip Code ______

Email ____________________ Additional Contact (Home, Cell, etc) ____________________

Patient Information:

Patient Name / ID ____________________ Owner's Name ____________________

Owners Phone ____________________ Other Owner Contact (Home, Cell, Email, etc) ____________________

Species ______ Breed ______ Sex: ☐ Female ☐ Male ☐ FS ☐ MN ______ Age ______ Weight ☐ Lb ☐ Kg ______

Tentative Diagnosis / Chief Complaint:

History / Physical Exam Findings:

Treatments (Please include medications and dosages):

Special Requests/Comments:

Please fax all records and lab work to (541) 282-7999