SOUTHERN OREGON
VETERINARY SPECIALTY CENTER

DVM 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 before the time of the appointment. Please fax records to (541) 282-7999

☐ Emergency/ Critical care ☐ Surgery ☐ Oncology ☐ Phone consultation
☐ Internal Medicine ☐ Dermatology ☐ Outpatient Ultrasound

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 | ☐ Female ☐ Male ☐ FS ☐ MN Sex | 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 email to sovsc@sovsc.com