



1. Please select the department you are referring to:

<input type="checkbox"/> Emergency • Please call and ask to speak to an ER DVM	<input type="checkbox"/> Surgery • Dr. Fugazzi (<i>Wed-Fri</i>)	<input type="checkbox"/> Internal Medicine • Dr. Winters (<i>Mon-Thur</i>) • Dr. Applegate (<i>Fri-Sun</i>)	<input type="checkbox"/> Critical Care • Dr. Seshadri (<i>Sat-Mon</i>)
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2. Please send all relevant records to us by Fax: (541) 282-7999 or Email: SOVSC@SOVSC.com

What record types should we be expecting (so we know what to watch for):

- Medical Records Including and DVM notes)
- Lab work: Yes No
- Imaging: Xray's CT MRI Prior U/S Reports Other: _____

3. Your Hospital Information:

Name:		Referring Doctor:	
Phone:	Email:	Fax:	

4. Your Client & Patient Information:

Client Last:		Client First:	
Client Phone:		Client Email:	
Patient Name:		Breed:	Species: K9 Fel
Age:	Color:	Weight: LB or KG	Sex: M F MN FS

5. Reason for Visit:

6. History & Exam Summary:

7. Treatments Given: (please provide medication and dosing)

8. Please confirm where you would like medical records sent at the conclusion of the visit

- Hospital email on file
- Alternate email address: _____