SOUTHERN OREGON
VETERINARY SPECIALTY CENTER

RDVM Referral Form

1. Please select the department you are referring to:

☐ Emergency	☐ Surgery	☐ Internal Medicine	☐ Critical Care
• Please call and ask to speak to an ER DVM	• Dr. Fugazzi *(Wed-Fri)*	• Dr. Winters *(Mon-Thur)* • Dr. Applegate *(Fri-Sun)*	• Dr. Seshadri *(Sat-Mon)*

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:_____