

PATIENT REFERRAL FORM

- Diagnostic Imaging
- Surgery
- Oncology
- Radiation therapy / Radioiodine



CLIENT INFORMATION	HOSPITAL INFORMATION
Client	Referring Dr.
Address	Hospital
Home Phone	Phone
Work Phone	FAX
Cell Phone	e-Mail
e-Mail	Best contact time?

PATIENT INFORMATION		
Name	Age	Vaccination Status Current/Lapsed
Species	Sex	HW Preventative Current/Lapsed
Breed	Weight lb/kg	Handling Precautions?

HISTORY/PHYSICAL EXAM

DIAGNOSTICS
<input type="checkbox"/> Lab data
<input type="checkbox"/> Radiographs
<input type="checkbox"/> Ultrasound / Echocardiogram

REFERRAL REQUEST	REFERRING VETERINARIAN'S SIGNATURE
<input type="checkbox"/> Regular Appointment	
<input type="checkbox"/> Emergency Appointment (next 24-48 hrs)	

PLEASE FAX ALL LAB DATA, IMAGING REPORTS, MEDICAL RECORDS and any information that will assist in diagnosis. In recognition of changes in patient condition, doctor's evaluation and client wishes, SLVS reserves the right to change diagnostic / therapeutic plans when clinical judgement dictates. Thank you for the referral!!!