Phone: (847) 459-7535

PATIENT REFERRAL INFORMATION

RDVMs: Please complete the pertinent portions of this form and give it to the patient's owner to bring for the initial consultation at VSC or fax it back to us. Please attach all relevant laboratory results, records and radiographs. When you need more referral forms, please feel free to contact us.

Thank you for trusting your patient to our care

OWNER

Name: ____________________

Home Phone: ____________________

REFERRING VETERINARIAN

Name: ____________________

Hospital: ____________________

PATIENT INFORMATION

Name: ____________________

Species: __________ Breed: __________

Date of Birth: __________ Sex: __________

Vaccination History

Type: __________ Date:__________ Type: __________ Date:__________ Type: __________ Date:__________

Known Allergies or Adverse Reactions____________________

RECEIVING SERVICE:

- ☐ Surgical Referral Service
- ☐ Veterinary Medical Referral Service
- ☐ VSC Emergency and Critical Care
- ☐ Midwest Veterinary Dermatology Service
- ☐ Imaging Center for Animals
- ☐ TheraPET Wellness Center
- ☐ Chicagoland Veterinary Behavior Consultants

REFERRAL TYPE:

- ☐ **Full Diagnostics & Treatment**
  - ☐ Interdepartmental referral OK
- ☐ **Partial Diagnostics & Treatment** ____________________
- ☐ **Consultation Only**

PRIMARY REASON FOR REFERRAL ____________________

HISTORY AND PHYSICAL FINDINGS

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LABORATORY AND RADIOGRAPHIC DATA

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- ☐ Laboratory reports attached
- ☐ Radiographic films attached (all radiographs will be returned with owner or by mail)

TREATMENT AND DIAGNOSIS

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PREVIOUS THERAPY AND MEDICATIONS

DRUG	DOSE	DATE(S)	DURATION OF TX	RESPONSE

FOR RADIOLOGY & IMAGING REFERRALS:

- ☐ Radiology
- ☐ Sonography
- ☐ CT
- ☐ Nuclear Medicine ____________________
- ☐ MRI
- ☐ I-131
- ☐ FNA
- ☐ Biopsy ____________________

Preferred Sedation: ____________________ Contrast: ____________________