Patient Referral Form

This form should be completed by a veterinarian. Boxes in red are required.

Referring Veterinarian's Information

First Name: _____ Last Name: _____

Clinic: _____

Email: _____

Would you like to receive VSC's Referring Veterinarian Newsletter?

☐ Yes, please ☐ No, thank you

Client's Information

First Name: _____ Last Name: _____

Phone: _____

Patient's Information

Patient's Name: _____ Species: Select One

Weight (kg): _____ Breed: _____

Age: _____ Sex: Select One

Referral Information

Type:

Select One
Anesthesia & Pain Management
Cardiology
Dermatology
Diagnostic Imaging
Emergency & Critical Care
Internal Medicine
I-131
Medical & Radiation Oncology
Neurology/Neurosurgery
Rehabilitation & Integrative Medicine
Surgery

Interdepartmental referral OK if necessary?

Select One

Medical Information

(Type NONE if applicable)

Primary Problem(s):

Pertinent Medical History:

Diagnostic Tests Performed/Results:

Current Medication(s):

Previous surgical and/or other procedure(s) and date(s):

Please attach a one-year history, current blood work, imaging, and any other relevant information.