Service referring to: Internal Medicine ☐ Surgery ☐ Oncology ☐

Referring DVM: Clinic:

Clinic Phone #: Clinic Email

Preferred method of contact : Phone ☐ Fax ☐ Email ☐

Client's Name: Client's Phone Number: Client's Email:

Patient's Name: Species: Breed:

Age: Weight (kg): Sex:

Reason for referral:

Pertinent Medical History and Clinical Findings:

Previous Diagnostics: (Please attach original images and reports)
CBC ☐ Chemistry ☐ UA ☐ Valley Fever Titer ☐

Radiographs ☐ if so, what views Abdominal Ultrasound ☐

Other diagnostics (i.e. culture, fluid analysis, etc.):

Medication History

Drug/Supplement	Dosage	Frequency	Duration of Therapy	Currently receiving?

Therapeutic/Surgical History:
Other Important Medical History: