VETERINARY REFERRAL AND EMERGENCY CENTER OF SOUTH TEXAS

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REFERRAL FORM

Please Circle One: Surgery Internal Medicine Radiology

Oncology Ophthalmology Dermatology

Referring Doctor:_____ Referring Clinic:_____

Phone: _____ Fax: _____

Email: _____ Date:_____

Client & Patient Information

Owner Name:_____ Home Phone:_____

Cell Phone: _____ Work Phone: _____

Address: _____

Pet Name: _____ Breed: _____

Sex: Male Neutered Female Spayed Age/DOB: _____

Weight: _____

Were Radiographs taken? Yes No If yes, date of study: _____

Brief History & Problem: _____
_____
_____

Tentative Diagnosis: _____
_____
_____

Procedure(s) Requested: _____

STATUS OF APPOINTMENT: EMERGENCY THIS WEEK ROUTINE

Please fax current lab work, biopsy reports, and medical records with this form.
Thank you!