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PATIENT REFERRAL FORM

CLIENT INFORMATION

Client Name(s) (First & Last): ____________________

Client Address: ____________________
(Street) (City) (State) (Zip Code)

Client Primary Phone: ____________ **Client E-mail:** ____________

REFERRING VETERINARIAN INFORMATION

DVM: ____________ **Hospital Name:** ____________

Hospital Address: ____________________
(Street) (City) (State) (Zip Code)

Phone: ____________ **Fax:** ____________ **E-mail:** ____________

PET INFORMATION

Patient Name: ____________ **Species:** ________ **Breed:** ____________

Age: ________ **Weight (Kg):** ________ **Sex:** **Male** **Male Neutered** **Female** **Female Spayed**

REFERRAL INFORMATION

Chief Complaint/Diagnosis: ____________________

Pertinent Medical History/Physical Findings/Duration of Current Surgical Problem: ____________________

Current Medication(s): ____________________

Special Requests/Comments: ____________________

Laboratory Data Available? **Yes** **No** ***(Ex – CBC, Urinalysis, Chemistry Profile, etc.)***
Please be sure to include pertinent history and exam notes with all diagnostics and e-mail to info@scissortailvets.com).

Radiographs Taken? **Yes** **No**
If YES, please send radiographs: **Films/Digital Rads sent with client** **Digital Rads e-mailed to** info@scissortailvets.com