REFERRAL FORM

To facilitate the efficiency of the consultation, we would greatly appreciate your assistance in filling out this form and returning it to us along with the pertinent lab data and 2+ years of medical records. This will allow us to spend more time with your client and patient. Thank you!

APPOINTMENT STATUS: Owner to call ____ Already scheduled _____ Emergency (call us first)_____

Primary care veterinarian: ____________________________ Your hospital: ______________________________________

Your phone: ___________________________ Your fax: _________________________ Date: ___________________________

Client name: _____________________________________ Client phone: ____

Patient name ___________________________ Signalment (age, sex, breed): ____________________________________

The Following Portion to be Completed by Primary Care Veterinarian

I am referring to (*please check*):

_____**Southern Colorado Veterinary Internal Medicine** *Indicate any specific requests:* Abdominal ultrasound _____ Thoracic ultrasound ___ Echocardiogram ___ Chemotherapy ___ CT scan ____ Endoscopy ____ Other___

_____ **Mountain View Veterinary Surgery** Indicate requested procedure: ____

Chief reason for referral: ____

Summary of concern(s): ____

____

Lab work (blood, urine, etc.) performed: No ____ Yes _____ If Yes, please list (CBC, chem, etc.) _________________________

____ Any lab work pending? __________________________

Medications/treatment: ____

____

Any other veterinary hospitals involved in this pet's care? No ___ Yes ___ If yes, indicate: ______________________________

Radiographs performed? No _____ Yes _____ If Yes, indicate: Email _____ Owner to carry _____ Mail _____

Ultrasound performed? No _____ Yes _____ If yes, indicate: Email _____ Owner to carry _____ Mail _____

Additional information: ____

Please send to (email) **FrontDesk.scvim@gmail.com** or (fax) **719.960.2541.** We appreciate your assistance and look forward to partnering with you on this case!