

# VALLEY CENTRAL VETERINARY REFERRAL AND EMERGENCY CENTER

## REFERRING VETERINARIAN REPORT

### Service(s) Requested

- Cardiology       Internal Medicine       Nuclear Medicine       Oncology       Emergency  
 Ophthalmology       Behavior       Surgery       Acupuncture       Pathology

Referred To: \_\_\_\_\_

### Preferred method of contact regarding this case:

- Phone       Fax       Email       Postal Mail

### Referring Veterinarian

Name \_\_\_\_\_ Hospital \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

### Client & Pet Information

Name \_\_\_\_\_ Breed \_\_\_\_\_  
Pet Name \_\_\_\_\_ Sex \_\_\_\_\_  
Species \_\_\_\_\_ Age \_\_\_\_\_

### Reason for Referral

\_\_\_\_\_  
\_\_\_\_\_

### History (attach copy of records)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Diagnostic test performed

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Treatment & Medications

\_\_\_\_\_  
\_\_\_\_\_

### Additional Comments

\_\_\_\_\_  
\_\_\_\_\_

- Enclosures (if any)       Lab Reports       Radiographs       Other

Please include radiographs, copies of laboratory test and a summary of the medical record. Radiographs will be returned promptly. Referral information may be mailed, sent with the client or sent via fax. If using mail please allow enough time for the information to arrive so it is available at the time of the consultation.

Please have the client call to make an appointment.

