DESERT VETERINARY MEDICAL SPECIALISTS

The experts in compassionate care.

REFERRAL FORM

☐ Cardiology ☐ Internal Medicine ☐ Radiology

Referring Veterinarian Name:		Date:
Hospital Name:		
Street Address:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		
Client Name:		
Home Phone:	Cell/Other:	
Patient Name:	Species:	
Breed:	Color:	Age/Birth Date:
Sex: ☐ M ☐ F	Altered: ☐ Yes ☐ No	
Primary Complaint/Reason for Referral:		

If you feel extra information is needed, please attach additional page(s). We ask that you send all radiographs, ultrasound, CT and MRI images **(even if they have no significant findings) with the client, and we will return them to your office.** Please FAX any original lab reports **to our office, as well as records directly relating to this medical condition. Please call our doctor if there is any immediate information you need to relay about this case.**

01/16

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