

Owners Name _____

Owners Address _____

Owners Phone _____

Owners E-mail _____

Pet Name _____ Species _____ Breed _____ Color _____

Date of Birth/Age _____ Weight _____ Gender: M MC F FS

Reason referral/Clinical History (include duration of illness, signs) _____

Please have your client call the appropriate service for an appointment once your referral has been submitted.

Date _____

Referring to _____

****If pet's condition requires an emergency appointment within 24hrs, please contact service by phone in addition to fax****

Referring Veterinarian _____

Clinic _____ E-mail _____

Phone _____ FAX _____

Diagnostic data accompanying referral Laboratory Radiographs Other Imaging

Vaccination History					
Canine			Feline		
Rabies	___ / ___ / ___		Rabies	___ / ___ / ___	
DHPP	___ / ___ / ___		FVRCP	___ / ___ / ___	
Leptospirosis	___ / ___ / ___		FeLV	___ / ___ / ___	
OTHER:	___ / ___ / ___		OTHER:	___ / ___ / ___	

Medical reason precluding rabies vaccination: _____

If unvaccinated, Senior Clinician approval for admittance: _____

Estimate Provided to Owner: \$ _____ to \$ _____

For internal use only:

Infectious disease suspected diagnosed _____

Is the animal displaying or have a history of:

- Loose stool, diarrhea or vomiting
- Respiratory illness – nasal discharge, coughing, sneezing
- Skin or wound infection
- Recent animal bite
- Aggressive behavior
- Seizures If yes, how long since last seizure? _____
- Other: _____

Special diet _____

Food Allergies Yes No _____

Raw diet Yes No _____