



Referral Form

Date of Appointment: _____ Time of Appointment: _____ Owner will call to make appointment

Referred to (check all that apply): Cardiology Internal Medicine Dermatology Surgery

<p><u>Client Information:</u> Client Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number(s): _____</p>	<p><u>Referring Vet Information:</u> Clinic Name: _____ Clinic ID: _____ Referring DVM: _____ Phone: _____ Fax: _____</p>										
<p><u>Patient Information:</u> Patient Name: _____ Breed: _____ Age: _____ Weight: _____ Sex: <input type="checkbox"/> Male, Intact <input type="checkbox"/> Female, Intact <input type="checkbox"/> Male, Neutered <input type="checkbox"/> Female, Spayed</p>	<p><u>Vaccination History:</u></p> <table border="1"> <thead> <tr> <th>Type</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td>Heartworm Antigen Test</td> <td><input type="checkbox"/> Positive <input type="checkbox"/> Negative</td> </tr> </tbody> </table>	Type	Date							Heartworm Antigen Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Type	Date										
Heartworm Antigen Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative										

Chief Complaint/Working Diagnosis:

History/Physical Findings:

Diagnostic Test Performed & Results: (please fax or attach)

Test(s) Pending (please list): _____

Treatments (including medications and dosages):

Special Requests/Comments:

Please bring this form, any relevant recent radiographs and all medications to your pet's initial exam.
 Ask your veterinarian if you need to withhold food or water before your appointment.

Institute of Veterinary Specialists
3603 NW 98th Street Suite A Gainesville, FL 32606
Phone: 1-888-844-1019 Fax: 1-888-844-7686