INSTITUTE OF VETERINARY SPECIALISTS

REFERRAL FORM

5609 SW 64th Street
Gainesville, FL 32608

Phone: **352-331-4233**
Fax: **352-331-9328**
Email: **reception@vetheart.com**

Date: _____

Patient Name:		IVS Patient ID:	
Breed:	Age:	Sex:	Weight:

PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS, RADIOGRAPHS, AND LAB RESULTS

Reason for Referral:

Radiographs and/or images may be emailed or alternatively a direct DICOM transfer to our PACS. E-mail contact@vetheart.com to set up.

No images ☐
DICOM ☐
Emailed ☐

Vaccination Status: Canine DA2P: _____ (Date Given) Feline FVRCP: _____ (Date Given) Rabies: 1 yr 3 yr _____ (Date Given)

Medical reason for precluding rabies vaccination (if any): _____

Animal Temperament:

Pertinent History: (Please fax or email a copy of medical history pertaining to admitting complaint)

Pertinent Lab Results: (Please send a complete copy of results and reference intervals from any lab)

No labs ☐
Emailed ☐
Faxed ☐

Current Medication/Treatment: (If complex/ongoing condition, please send medical records showing meds/treatment)

CLINIC USE ONLY

Referring Veterinarian:
First Last

Appointment Date:
Appointment Time:

Veterinary Clinic:
Address:
City: State: Zip:
Phone: Fax:
E-Mail:

Estimate Given: $
yes no

Communication with:

*Must be completed by referring veterinarian and faxed or emailed prior to appointment.