INSTITUTE OF VETERINARY SPECIALISTS

OPHTHALMOLOGY REFERRAL FORM

5609 SW 64th Street
Gainesville, FL 32608

Ophthalmology Referral
Phone: **352-331-4233**
Fax: **352-331-9328**
Email: **mobile@vetheart.com**

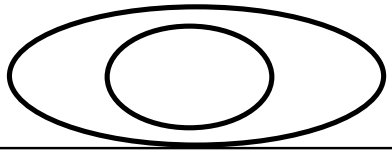
Date: _____

Patient Name:		IVS Patient ID:	
Breed:	Age:	Sex:	Weight:
Owner's Name:		Phone Number:	
Address:		Email:	

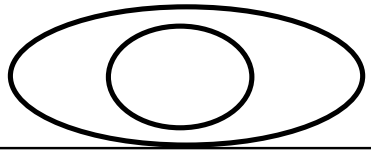
PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS, PHOTOGRAPHS, AND LAB RESULTS

Reason for Referral:

Right Eye:



Left Eye:



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:

Previous Medication/Treatment:

Appointment Type Request:
In-House: ☐ Urgent: ☐
The Villages: ☐ Stable: ☐

Same-Day emergency appointments will have a $75 emergency fee, and most cases will require a drop-off appointment.

Referring Veterinarian:
First Last

Appointment Date:
Appointment Time:

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

Owner Contacted:
yes no

Communication with:

*For office us only

*Must be completed by referring veterinarian and faxed or emailed to schedule an appointment