

SHAW PET HOSPITALS

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REFERRAL INFORMATION FORM

VETERINARIAN INFORMATION:

Date: _____

Veterinarian: _____ Hospital _____

Phone: _____ Fax: _____ Address: _____

Reason for Referral:

- I-131 Ultrasound Endoscopy SA Surgery Equine Surgery
- Laparoscopy Thoracoscopy

PATIENT INFORMATION:

Client's Name: _____ Address: _____

Phone: (H) _____ (W) _____ CELL _____

Patient's Name: _____ Sex: _____ Birthdate: _____ Body Weight: _____

Species: _____ Breed: _____ Vaccine Status: _____

Patients Temperament: Good Nervous Dominant Aggressive

STATUS: **URGENT** **NON-URGENT**

CLINICAL HISTORY:

Present Conditions & Clinical Signs: _____

Treatment & Response (include drug dosage): _____

Tentative Diagnosis, Comments & Concerns: _____

Previous Conditions / Surgeries: _____

Previous or Current Systemic Disease, Medications, or Adverse Reactions: _____

Lab History (please fax most recent / relevant lab work and medical records) Tests performed: _____

