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Veterinarian Referral Form – Surgery & CT Imaging

Referring Veterinarian:____

Referring Clinic: ____

Referring Clinic Phone: ________________________________

Referring Clinic Email:_________________________________

Client Information

Client Name: ____

Phone Number(s): ____

Patient Information

Patient's Name: ____

Species: ☐ Dog ☐ Cat Patient Age/Date of Birth: _____________

Patient Sex: ☐ M ☐ MN ☐ F ☐ FS

Breed: __________________________________

Medical Information

Presenting Complaint: ____

Preliminary Diagnosis: ____

Referral Service: ☐ Surgery ☐ CT

Pertinent Medical History:

Diagnostics:

Other Pertinent Information**:**

Please include all pertinent records and images in order to facilitate your patient's referral!