Cascade Veterinary
REFERRAL CENTER
SPECIALTY & EMERGENCY

11140 SW 68th Pkwy, Tigard, OR 97223
503-684-1800
specialty@cascadevrc.com
www.cascadevrc.com

Internal Medicine Referral Form

Veterinarian Information

Referring Veterinarian: _____

Referring Clinic: _____

Referring Clinic Phone: _____

Referring Clinic E-mail: _____

RDVM's Clinical Days: Appointments for your client and patient may be best made on days that rDVM is in the clinic in the event there is a need to relay critical results and case communication:

_____

Client Information

Name(s): First: _____ Last: _____

Phone Number(s): _____

E-mail(s): _____

Patient Information

Name: _____

Species: ☐ Dog ☐ Cat

Date of Birth / Age: _____

Sex: ☐ Intact Male ☐ Neutered Male
☐ Intact Female ☐ Spayed Female

Breed: _____

Referral Information

Pertinent Medical History

Completed Diagnostic Tests and Pertinent Results

Current Medications and Supplements

Medication / Suppl.	Concentration	Instructions

Current Diet

Medical Records

Please submit all previous medical records, including all chart notes, diagnostic test results (original copies), and images, either by uploading here or emailing to specialty@cascadevrc.com.