Cascade Veterinary
REFERRAL CENTER
SPECIALTY & EMERGENCY

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

Outpatient Abdominal Ultrasound Referral Form

Veterinarian Information

Referring Veterinarian: _____
-- Please include referring veterinarian's working days to facilitate case update on the day of your patient's appointment:

Referring Clinic: _____

Referring Clinic Phone: _____

Referring Clinic Email: _____

Billing: ☐ Direct bill **client**

☐ Direct bill **clinic** *pre-authorization must be on file for this option
Please contact our Specialty Coordinator, Jennifer Frank (jfrank@cascadevrc.com) to setup your clinic for direct billing

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Client Information

Client Name: _____

Phone Number(s): _____

Email(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 Summary
-- Assessment and recommendations on your patient are based on clinical information provided. To best facilitate your patient's care, please provide a summary of pertinent patient history (e.g., clinical course, physical exam findings, etc.) including list of diagnostic tests and results, and response to treatments.