FAX 866-235-9691

VETERINARY REFERRAL FORM

☐ **Please complete the following and return by fax or email:**

Client first & last name: _____

Patient name:_____

Client contact phone number(s): _____

Client email address:_____

Species: Dog or Cat **Breed:**_____

Sex (circle): Male/Female **and** Neutered/Spayed **Age** (or date of birth)**:**_____

☐ **Please indicate the primary reason for referral** (eg post-surgical rehabilitation, weight loss, sport dog or geriatric conditioning)**:** _____

_____

_____

_____

☐ **Please attach all relevant medical history and radiographs.**

As the referring veterinarian, I understand that I remain the primary care provider.

_____ _____ _____

DVM Signature **Printed/typed name of DVM** **Date**

Clinic name: _____ **Clinic phone number:** _____

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