



Referral Form

Please send a completed referral form along with copies of radiographs, all lab work, ECG's and other pertinent medical records before the time of the appointment. Please fax records to (541) 282-7999

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Emergency/ Critical care | <input type="checkbox"/> Surgery | <input type="checkbox"/> Oncology | <input type="checkbox"/> Phone consultation |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Outpatient Ultrasound | |

Requesting Clinic Information:

_____ Doctor	_____ Hospital		
_____ Phone	_____ Street Address		
_____ Fax	_____ City	_____ State	_____ Zip Code
_____ Email	_____ Additional Contact (Home, Cell, etc)		

Patient Information:

_____ Patient Name / ID	_____ Owner's Name			
_____ Owners Phone	_____ Other Owner Contact (Home, Cell, Email, etc)			
_____ Species	_____ Breed	<input type="checkbox"/> Female	<input type="checkbox"/> FS	<input type="checkbox"/> Lb
		<input type="checkbox"/> Male	<input type="checkbox"/> MN	<input type="checkbox"/> Kg
		_____ Sex	_____ Age	_____ Weight

Tentative Diagnosis / Chief Complaint:

History / Physical Exam Findings:

Treatments (Please include medications and dosages):

Special Requests/Comments:

Please fax all records and lab work to (541) 282-7999

