SOUTHERN OREGON
VETERINARY SPECIALTY CENTER

RDVM Referral Form

1. **Please select the department you are referring to:**

☐ Emergency	☐ Surgery	☐ Internal Medicine
• Call ahead and ask to speak to an ER DVM or your case may not be seen.	• Dr. Fugazzi *(Wed-Fri)*	• Dr. Winters *(Mon-Thur)* • Dr. Applegate *(Fri-Sat)*

2. **Please send all relevant records to us by Fax: (541) 282-7999 or Email: SOVSC@SOVSC.com What record types should we be expecting** (so we know what to watch for)**:**
   ☐ Medical Records Including and DVM notes
   ☐ Lab work: ☐ Yes ☐ No
   ☐ Imaging: ☐ Xray's ☐ C T ☐ MRI ☐ Prior U/S Reports ☐ Other:

3. **Your Hospital Information:**

Name:		**Referring Doctor:**
Phone:	**Email:**	**Fax:**

4. **Your Client & Patient Information:**

Client Last:		**Client First:**	
Client Phone:		**Client Email:**	
Patient Name:	**Breed:**		**Species:**
Age:	**Color:**	**Weight:**	**Sex:**

5. **Reason for Visit:**

6. **History & Exam Summary:**

7. **Treatments Given:** (please provide medication and dosing)

8. **Please confirm where you would like medical records sent at the conclusion of the visit**
   ☐ Hospital email on file
   ☐ Alternate email address:_____