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Surgical Consultation Referral Form

Dr. Mark Fuller B.Sc, DVM, DACVS-SA

CLIENT AND PATIENT INFORMATION:

Client Name: ___________________________________ Appt Date: ________________________

Client Address: ____
____
____

Primary Contact Number: ( ) ______________________ Additional: ( )________________________

Patient Name: ___________________ Breed: _______________Wt:_______ Sex: ________Age:_______

REFERRAL VETERINARY INFORMATION:

Referring Hospital: _______________________________ Veterinarian: ________________________

Phone: ( ) _______________ Fax: ( ) __________________ Email: ___________________________

REASON FOR REFERRAL (BRIEF HISTORY WITH DURATION):

____
____
____
____
____

Please fax or email us all laboratory results and radiographs prior to the appointment date.

CURRENT MEDICATIONS: (please list current meds and duration)

____
____
____

RADIOGRAPHS: Taken: _____ Not Taken: ______

Emailed: ____ (jpeg images preferred) Coming with owner: ________