REFERRALS

Referring Veterinary Surgeon

Name

Practice Name

Address

Telephone

Email

Postcode

Client Details

Name

Preferred Contact

Telephone Number

Name

Telephone Number

Name

Telephone Number

Name

Address

Email

Postcode

Patient Details

Name

Species

Breed

Date of Birth

Sex

Male

Female

Neutered

YES

NO

REFERRALS

Case Details

Service to be referred to

- ☐ Canine Internal Medicine
- ☐ Feline Internal Medicine
- ☐ Neurology & Neurosurgery
- ☐ Orthopaedics
- ☐ Soft Tissue Surgery
- ☐ Interventional Radiology

Reason for referral

Does this case need an urgent appointment?

☐ YES

Date condition started?

History

REFERRALS

Case Details cont.

Medications being used

Tests available

Please indicate which (if any) tests that are available and send any supporting documents to this request.

- ☐ Radiographs (film)
- ☐ Radiographs (digital)
- ☐ Blood Results
- ☐ Urinalysis
- ☐ ECG
- ☐ Ultrasound
- ☐ Biopsy/histopath

Other test information (if relevant)

Have we given you an estimate for this referral?
(estimates for common conditions are available on our website or otherwise please call us on 01506 888 777)

Have you given the client an estimate for the referral, if so what figures were they given?

Is the client aware they will need to leave a deposit?

- ☐ YES
- ☐ NO