



Referral Form

This information must be available at the time of service or we may need to reschedule the appointment.
Thank you for your referral.

rDVM Information

Referring Doctor:		Phone:	
Hospital Name:		Fax:	
Hospital Address:		Best time to call:	
Email Address:	Preferred method of contact: <input type="checkbox"/> phone <input type="checkbox"/> fax <input type="checkbox"/> e-mail		

Service Location: Mobile In Hospital at Salt River

Patient Information

Owner's Name:		Phone:	
Owner's Address:			
Pet's Name:		Species: <input type="checkbox"/> canine <input type="checkbox"/> feline <input type="checkbox"/> other	
Breed(s):	Birthdate (or approx. age):	Color:	Weight:
Current on vaccines: <input type="checkbox"/> yes <input type="checkbox"/> no	Spayed/Neutered: <input type="checkbox"/> yes <input type="checkbox"/> no	Sex: <input type="checkbox"/> male <input type="checkbox"/> female	
Presenting problem:			
History/Pertinent Physical Findings/Treatment:			

Condition of patient: healthy stable critical

Examination Requested: Ultrasound only Internal Med Consult

Ultrasound location: Abdominal Thoracic Bi-cavitary Neck Other

Reason for ultrasound:

<p>Additional Requests: <i>(If indicated by ultrasound, please select any of the procedures to the right that you would like performed. Some of these procedures may require sedation or anesthesia.)</i></p>	<input type="checkbox"/> Fine needle aspirate <input type="checkbox"/> Fluid sample <input type="checkbox"/> Cystocentesis
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CLIENT COMMUNICATION: All clinical findings and images will be provided to the referring veterinarian following the examination. For ultrasounds only, the referring veterinarian is responsible for informing the client of the findings.

I have reviewed and completed this form for submission to Salt River Veterinary Specialists for the evaluation of my patient. _____

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