SALT RIVER
VETERINARY SPECIALISTS

Date: _____

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: ☐ phone ☐ fax ☐ e-mail

Service Location:

☐ **Mobile** ☐ **In Hospital at Salt River**

Patient Information

Owner's Name:			Phone:
Owner's Address:			
Pet's Name:	Species: ☐ canine ☐ feline ☐ other		
Breed(s):	Birthday *(or approx. age)*:	Color:	Weight:
Current on vaccines: ☐ yes ☐ no	Spayed/Neutered: ☐ yes ☐ no		Sex: ☐ male ☐ female
Presenting problem:			
History/Pertinent Physical Findings/Treatment:			
Condition of patient: ☐ healthy ☐ stable ☐ critical			

Examination Requested:

☐ **Ultrasound only** ☐ **Internal Med Consult** ☐ **Surgery Consult**

Ultrasound location: ☐ **Abdominal** ☐ **Thoracic** ☐ **Bi-cavitary** ☐ **Neck** ☐ **Other**

Reason for ultrasound:

Additional Requests:
(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.)

☐ Fine needle aspirate
☐ Fluid sample ☐ Cystocentesis

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. ▶ _____

Referral Form

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