Veterinarian Referral Form

DATE: ____________________

Please mark status of appointment: ☐ Immediately ☐ This Week ☐ Non-Emergency

Please mark the service needed for the patient below:

☐ Critical Care
☐ Diagnostic Imaging
☐ Dentistry & Oral Surgery
☐ Internal Medicine
☐ Oncology
☐ Radioactive Iodine Therapy
☐ Rehabilitation & Fitness (See required signature below)
☐ Sports Medicine
☐ Surgery & Orthopedics

Specified Doctor (optional): ____

Please fax to **(512) 343-2844** or submit electronically to **info@austinvets.com.**

REFERRING DR: ______________________________ CLINIC NAME: ____

PHONE: ____ FAX: ____

EMAIL: ____

What is your preferred contact method? ____

CLIENT/PATIENT INFORMATION

OWNER NAME: ___________________________________ CO-OWNER: _____________________________________

PHONE (H): _________________________ (W): _________________________ (C): ____________________________

PET NAME: ____ BREED: ____

SEX: Male Neutered Female Spayed Age/DOB: _____________ Weight: _________lb __________kg

MEDICAL RECORDS, PERTINENT LABWORK AND RADIOGRAPHS

Have radiographs been taken? ☐ Yes ☐ No Date of study: ______________________________________

Have medical records, lab work, and/or radiographs: ☐ Been Faxed ☐ Been E-Mailed ☐ Owner Bringing

Brief History & Primary Complaint: ____

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Tentative Diagnosis: ____

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→ Please send current lab work, biopsy reports, and medical records with this form.
→ Please email, fax or send copies of radiographs with the owner.

Rehabilitation and Fitness: *As the attending veterinarian, I have determined that rehabilitation will not likely be harmful to the patient.*

____ ______________________

Referring Veterinarian's Signature Date