



Veterinarian Referral Form

DATE: _____

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

Please mark the service needed for the patient below:

- | | |
|---|--|
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Radioactive Iodine Therapy |
| <input type="checkbox"/> Dentistry & Oral Surgery | <input type="checkbox"/> Rehabilitation & Fitness (See required signature below) |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Neurology & Neurosurgery | <input type="checkbox"/> 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 E-Mailed Owner Bringing

Brief History & Primary Complaint: _____

Tentative Diagnosis: _____

→ 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