Veterinarian Referral Form

DATE: ______________________

Please mark status of appointment: Urgent Next Available Appointment

*Please call our hospital at **512-343-2837** if you would like to speak with one of our specialists or emergency doctors if your patient is in need of immediate care.

Please mark the service needed for the patient below:

____ Surgery and Orthopedics ____ Neurology and Neurosurgery

____ Internal Medicine ____ Interventional Radiology

____ Oncology ____ Critical Care

Specified Doctor (optional):____

Reason for Referral/Primary Complaint

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Clinic Information

Referring DVM: ____________________________Clinic Name: ____

Phone: ____Fax: ____

Email: ____

What is your preferred contact method? ____

Client/Patient Information

Client Name: ______________________________ Co-owner Name: ______________________________

Phone : ____

Email: ____

Patient Name: ________________________________ Breed: ______________________________________

Sex: ____ Male ____Neutered
____ Female ____ Spayed Age/DOB: ___________ Weight: _______ lbs/kg

Medical Records, Pertinant Labwork and Radiographs

Have radiographs been taken? Yes No Date of Most Recent Study:

Has labwork been performed? Yes No Date of Most Recent Labwork:

Do you anticipate this patient to need an ultrasound? Yes No

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

If you have any questions or concerns regarding your referral, please call our hospital at 512-343-2837 so we can assist you further.

If you would like to set up an online veterinarian referral portal login, please email portal@austinvets.com.
For any technical issues with your referral portal, please email portal@austinvets.com.

Thank you for trusting AVES with your patient's care and for your continued collaboration!