VSH
VETERINARY SPECIALTY HOSPITAL

4019 Hood Road
Palm Beach Gardens, FL 33410
Phone: (561)625-9995
Fax: (561)625-9954
Email: vshreception@gmail.com

PATIENT REFERRAL INFORMATION

RDVMs: Please complete the pertinent portions of this form and give it to the patient's owner to bring for the initial consultation or fax it to us. Please attach all relevant laboratory results, medical records and radiographs. Please contact us if you need more referral forms.

Thank you for trusting your patient to our care.

OWNER

Name:_____

Primary Phone:_____

REFERRING VETERINARIAN

Name:_____

Hospital:_____

PATIENT INFORMATION

Name:_____ Species:_____ Breed:_____

Date of Birth:_____ Sex:_____

Known Allergies or Adverse Reactions:_____

Would you like us to call this client and schedule an appointment? ☐ Yes ☐ No

****If this is an emergency case, would you like this case returned the following day? ☐ Yes ☐ No**

RECEIVING SERVICE

- ☐ Surgical Referral Service
- ☐ Internal Medicine
- ☐ Cardiology
- ☐ Emergency and Critical Care
- ☐ Oncology
- ☐ I-131 Radioactive Iodine
- ☐ Dermatology
- ☐ Neurology
- ☐ Other_____

**Please specify the Veterinarian you are referring to: _____

PRIMARY REASON FOR REFERRAL_____

HISTORY AND PHYSICAL FINDINGS (List all pre-existing concerns)

_____

_____

_____

_____

LABORATORY AND RADIOGRAPHIC DATA (Pending/Final results)

_____

_____

_____

- ☐ **Laboratory reports attached**
- ☐ **Radiographic films attached**

CURRENT TREATMENTS/MEDICINES (Include dosages/times)

_____

_____

_____

_____

RADIOLOGY AND IMAGING REFERRALS

- ☐ Radiology
- ☐ Sonography
- ☐ I-131
- ☐ CT
- ☐ Nuclear Medicine
- ☐ Contrast Study
- ☐ Fluoroscopy
- ☐ Other

Preferred Sedation: _____ **Contrast:** _____

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Remember, at VSH, your pets are our family!