

TU-VTH SMALL ANIMAL PATIENT REFERRAL FORM

Please call us at 334-727-8436 to confirm the referral and help us address any questions in person

Please type and email the form (and include labs and/or radiographs as PDF attachments) to: tucvmvetcare@tuskegee.edu
 Services Requested (Please check the box to the *left* of the service requested):

<input type="checkbox"/>	Internal Medicine	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	Internal Medicine (Cardiac)	<input type="checkbox"/>	Dentistry/Oral Surgery
<input type="checkbox"/>	Emergency & Critical Care	<input type="checkbox"/>	Other:

Referring Veterinarian Information

Date:		Patient name:	
Doctor name:		Client First and Last name:	
Hospital name:		Client's contact Phone#:	
Phone #		Species and Breed:	
Fax #		Weight, Sex & Age:	
Email:		Date of last 2 Rabies Vacc .:	

How would you like to be contacted? (Please check the box next to the *left* of the contact method requested)

<input type="checkbox"/>	Phone	<input type="checkbox"/>	E-mail	
<input type="checkbox"/>	Fax	<input type="checkbox"/>	Mail	Address:

Patient History

Summary of Diagnostics (Please attach a copy of completed Tests, Labs and Medical Records)

<input type="checkbox"/>	Check box if sending X-rays or other diagnostic images with client
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Treatments Medications (Please include vaccination history)

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Additional Comments