TU-VTH PATIENT REFERRAL FORM

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

Services Requested (Please check box to the *left* of the service requested):

	Internal Medicine		Surgery
	Internal Medicine (Cardiac)		Dentistry/Oral Surgery
	Emergency & Critical Care		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 box next to the *left* of the contact method requested)

	Phone		E-mail	
	Fax		Mail	Address:

Patient History

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

	Check box if sending X-rays or other diagnostic images with client

Treatments Medications *(Please include vaccination history)*

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Additional Comments