Circle City Veterinary Specialty & Emergency Hospital
9650 Mayflower Park Drive
Carmel, IN 46032
(317) 872-8387 Fax: (317) 872-1964 www.circlecityvets.com

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Diplomate, ACVS

**SURGERY
REFERRAL FORM**

Attention to referring veterinarian: Please complete the following information regarding your patient and fax, mail, *or* send with your client for their first appointment.

Date______________________

CLIENT:

Name______________________________________

Address____________________________________

City______________ State____ Zip Code_________

PATIENT:

Name__________________ Species_________________

Breed________________ Sex_____ DOB_____________

Vaccinations current: Yes__ Date Given________ No___

Is this animal known to be aggressive? Yes____ No_____

Referring Veterinarian__________________________ Hospital/Clinic Name______________________________

Address__________________________________ City_______________________ State____ Zip Code________

Phone________________________________Fax_________________________Email________________________

Reason for referral ____

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History, clinical signs, laboratory findings ____

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____

Tentative diagnosis____

Patient's overall condition: Good___ Fair___ Poor___ Lab work: Yes___ No___ Radiographs: Yes___ No___

Current Therapy____

____

Medication _____________________ Date _______ Dose/Frequency_______________ Response_____________

_____________________ _______ _______________ _____________

_____________________ _______ _______________ _____________

Comments ____

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Please remember to include complete copies of your patient's medical records and lab results.

A summary of each visit will be forwarded to you and your client. Inquiries, comments, and suggestions are always welcome. Thank you for your referral.

12/23/2008