



## VCA Advanced Veterinary Care Center

7712 Crosspoint Commons

Fishers, IN 46038

317-578-4100 / 317-578-4900 (fax)

Website: [www.indyvetspecialists.com](http://www.indyvetspecialists.com) / Email: [indyavcc@vca.com](mailto:indyavcc@vca.com)

Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Pet's name: \_\_\_\_\_ Species: ☐ feline ☐ canine Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ Female- unaltered ☐ Female-spayed ☐ Male-unaltered ☐ Male-neutered

Past & Current Medical History and Diagnostic Findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please attach any pertinent lab results and x-rays:** ☐ email ☐ USPS ☐ Client (will be returned via client)

### Referral Information:

#### **Surgery/Orthopedic:** \_\_\_\_\_

Lauren Pugliese, DVM, MS, DACVS-SA  
Nicolas Vecchio, DVM, DACVS-SA, CCRP

#### **Internal Medicine:** \_\_\_\_\_

Rikki Fitzpatrick, DVM, MS, DACVIM  
Timothy Hui, DVM, MS, DACVIM

#### **Neurology/Neurosurgery:** \_\_\_\_\_

Johnny Cross, DVM, DACVIM,  
Medical Director  
Andrea Sangster, DVM, MS, DACVIM

#### **Emergency Services:** \_\_\_\_\_

Anne Browne, DVM  
Andrea Compton, DVM  
Victoria Lewis, DVM  
Michelle Reckard, DVM, MPH  
Trinity Smith, DVM  
Zoltan Szilagyi, DVM  
Katherine Wentworth, DVM

#### **Nutrition:** \_\_\_\_\_

Beth Hamper, DVM, PhD, DACVN

#### **Physical Rehab:** \_\_\_\_\_

Emily Talaga, DVM, CCRP

#### **Ophthalmology:** \_\_\_\_\_

Carl Budelsky, DVM, DACVO

#### **Oncology:** \_\_\_\_\_

Emily Manor, DVM, DACVIM  
Kerri Rechner, DVM, DACVR

#### **Radiology:** \_\_\_\_\_

Kelsey Cline, DVM, MS, DACVR Debra Baird, DVM, DACVR

**Outpatient Imaging:** \_\_\_\_\_ Ultrasound

**Outpatient Reading:** \_\_\_\_\_ X-ray \_\_\_\_\_ CT

**\* Referral must be present and include specific diagnostic request before outpatient imaging is scheduled;  
client will not consult directly with radiologist for outpatient imaging**

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

It is a pleasure working with you and your client. We will be in touch with you concerning our recommendation and/or treatment. Please feel free to contact us with any questions/concerns regarding your referral. Thank you, AVCC Staff

Do you need more referral forms: ☐ Y ☐ N

Do you need more referral brochures: ☐ Y ☐ N