

Date: _____ # of pgs in fax: _____



PATIENT REFERRAL FORM

☐ Dallas adccustomer@vca.com (preferred)

972-267-8300 / Fax: 972-267-8301

Critical Care: Dr. Aslanian, Dr. Porterpan

Internal Medicine: Dr. Miller, Dr. Rifkin, & Dr. Waters

Internal Medicine/Cardiology: Dr. Nitsche

adc.oncology@vca.com

Oncology: Dr. Custis, Dr. Roof & Dr. Wright,

Jesse Dawson, DVM (Practice Limited to Oncology)

☐ Plano adcp@vca.com

214-667-2244 / Fax: 214-667-2250

Internal Medicine/Cardiology: Dr. Bronstad, & Dr. Rolfe

1 CLIENT / HOSPITAL INFORMATION

Client	Referring Dr.
Home Phone	Hospital
Work/Cell Phone	Phone
Other	Email

2 PATIENT INFORMATION

Name	Sex	M / MN / F / FS	Vaccine Status	Current / Lapsed
Species	Canine / Feline	Age	HW Preventative	Current / Lapsed
Breed	Weight	lb/ kg	Handling Precautions?	

HISTORY / PE

DIAGNOSTICS

☐ Lab Data

☐ Radiographs

☐ Ultrasound / Echo

(Please send all images)

TENTATIVE DX

COMMENTS

3 REFERRAL REQUEST

- ☐ Regular Appointment (Next 7-14 days)
- ☐ Urgent Appointment (Next 3-6 days)
- ☐ Emergency Appointment (Next 24-48 hours)

Please fax and/or email all **medical records, lab data, imaging reports** and any other information that will assist in diagnosis to preferred location (see above). Thank you for your referral.