Date: _____ # of pgs in fax: _____

PATIENT REFERRAL FORM

☐ Dallas **adccustomercare@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

Oncology: Dr. Custis, Dr. Roof & Dr. Wright,
Jesse Dawson, DVM (Practice Limited to Oncology)

☐ Plano **adcplano@vca.com** ***(preferred)***
214-667-2244 /Fax: 214-367-3904
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 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.