



# VCA Animal Specialty Group General Referral Form

## Referral Information

Referring Doctor:		Phone:	
Hospital:		Fax:	
Email Address:		Preferred Contact:	Phone <input type="checkbox"/> Email <input type="checkbox"/>

## Patient Information

Pet Name:		Phone:	
Owner's Name:		Email Address:	
Canine <input type="checkbox"/> Feline <input type="checkbox"/> Other <input type="checkbox"/>		Preferred Contact:	Phone <input type="checkbox"/> Email <input type="checkbox"/>
Current Vaccinations:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Age:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Presenting Problem:			

## Patient Condition

Healthy <input type="checkbox"/>	Stable <input type="checkbox"/>	Critical <input type="checkbox"/>	Moribund <input type="checkbox"/>
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## Diagnostic Tests Performed - Please include date, results, or if pending, your lab/hospital contact info

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## Treatments/Medications - Please include dates if possible

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## Response To Therapy

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## Additional Comments

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Please include radiographs, copies of laboratory tests and a summary of the medical record. Radiographs will be returned promptly. Referral information may be mailed, sent with the client, or sent via fax. If using the mail, please allow enough time for the information to arrive so it is available at the time of the consultation. Phone consults are welcome and encouraged. Please have client call to schedule an appointment with a specialist.



VCA Animal Specialty Group

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