VCA Palm Beach Veterinary Specialists
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Patient Referral Form

Appointment Date: _____ Time: _____
Primary Care DVM: _____ Referred to Doctor/Dept.: _____
Primary Care Hospital: _____
Address: _____
Phone: _____ Backline: _____
Fax: _____ Email: _____

Services Requested:
Complete Specialty Consult: _____
Contact Preference: _____
Specific Diagnostics: _____
Specific Treatment: _____

If available, please send the following patient information with your client:
❒ Medical Notes/Records
❒ Lab Work Results
❒ X-rays
❒ Imaging
❒ Treatments, including last time administered
❒ Other: _____

Name of Client/Agent: _____ Co-Owner: _____
Main Phone: _____ Alt. Phone Number: _____
Email: _____ Other: _____
Address: _____
❒ Client has CareCredit ❒ Client has Pet Insurance

Patient Name: _____
Species: _____ Breed: _____
Age: _____ Color: _____
Sex: ❒ F ❒ SF ❒ M ❒ CM ❒ Unknown

Tentative Diagnosis/Chief Complaint: _____

History/Physical Findings: _____

Treatment (including medications and dosages): _____

Special Requests/Comments: _____