 VETERINARY SPECIALISTS OF WESTERN NEW YORK

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**Referral form for Surgery – Dr. van Ee**

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| **REFERRING DR**: **HOSPITAL**: **HOSP. PHONE**: |

Owner’s Name: Phone #

Address:

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Breed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Sex: Species:

**RABIES: / / 1 or 3yr DHPP/FVRCP**: / / **1 or 3yr** Vaccines **MUST** be current for Procedure.

If not current provide reason and include exemption form.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach any recent blood/labwork:**

Date Referred: \_Duration of problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were radiographs done? YES NO - if yes, they were e-mailed disc/films sent with owner other

Reason for Referral:

History (include any treatments, dates, etc):

Special considerations:

Current medications & dosages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Request referral letters to be e-mailed to: or faxed (#)

Visit us at www.sheridananimalhospital.com for more referral forms Rev. 4/17