PATIENT REFERRAL FORM

VCA Animal Specialty Center
3912 Fernandina Rd.
Columbia, SC 29210
Ph 803.798.0803 | Fx 803.798.7916
Referral Line: 803-454-6152

Date

Referral to (check off your department selection below)

☐ Soft Tissue Surgery ☐ Ophthalmology ☐ Orthopedic Surgery ☐ Neurology ☐ Rehabilitation

Referring Veterinarian/Clinic Information

Referring DVM and Clinic Name

Address/State/Zip

Telephone Fax

Email

Patient Information

Patient Name
DOB Age
☐ Male ☐ Female Altered? ☐ Yes ☐ No

Species
Breed
Color

Pet Owner's Name and Contact Information

Name

Address/State/Zip

Home Tel Work Tel Mobile Tel

Email

PATIENT CASE HISTORY

Condition of patient ☐ Healthy ☐ Stable ☐ Critical

Presenting complaint/chief medical concerns

Reason for referral

Pertinent Medical History (including vaccination history)

Current Diagnostics/Treatments/Medications (including dosages)

Sending with patient:
☐ copy of entire medical record ☐ lab reports
☐ radiograph ☐ Other medical records (please specify)

PLEASE COMPLETE THIS FORM AND FAX TO 803-798-7916 OR EMAIL IT TO AU897@VCAHOSPITALS.COM