FAX TO: (970) 663-6273

Total # of pages

**REFERRAL FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referred to: | | | Referred By Dr: | | | |
| Referring Hospital: | | | | | | |
| Address: | | | | | | |
| Phone: | Fax: | | | | Email: | |
| How would you like to be contacted? (circle one) | | Fax | | Email | US Mail | Phone |

|  |  |  |
| --- | --- | --- |
| Name of Client: | | |
| Address of Client: | | |
| Home Phone: | Work Phone: | Cell Phone: |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | Species: (circle one): | | | Canine | | | | Feline | | |
| Breed: | Age: | Sex:(circle one) | | | F | SF | M | | NM | Unknown |
| Appointment Date/Time: | | | Estimated Time of Arrival: | | | | | | | |

|  |
| --- |
| Tentative Diagnosis/Chief Complaint: |
|  |
|  |

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| --- |
| Laboratory Data (Attach copies of results) |
|  |

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| --- |
| Treatments (Include medications and dosages) |
|  |
|  |

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| --- |
| Radiographs (Films will be returned) |
|  |

|  |
| --- |
| Special Requests / Comments |
|  |

**Our highly qualified and compassionate doctors include:**

**Surgery**

Michael Green, DVM DACVS

Jessica Barrera, DVM, MS, DACVS, ACVS Fellow, Surgical Oncology

**Internal Medicine**

Meredith Sherrill, DVM, DACVIM (SAIM)

Cynthia Panek, DVM, DACVIM

**Neurology**

Amy Komitor, DVM, DACVIM (Neurology)

David Raczek, DVM, DACVIM (Neurology)

**Emergency and Critical Care**

Susan White, DVM

Kristen Baumgartner, DVM

Leigh Browning, DVM

**Physical Therapy**

Carrie Adrian, PT, PhD, CCRP

**Acupuncture**

Joey Sneva, DVM, cVMA

24-Hour Emergency Center

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