Veterinary Surgery Service Patient Referral Form

131 Hospital Drive NE, Suite 2 / Ft. Walton Beach, FL 32548 / 850-737-2333 / FAX 888-654-3567 / Email: surgery@surgeryvet.com

John R. Wight, DVM / Michael P. Vitucci, DVM

DATE:

REFERRAL TO (CHECK SELECTION BELOW)

☐ Diagnostic Imaging	☐ Neurology/Neurosurgery
☐ Soft Tissue Surgery	☐ Rehabilitation
☐ Orthopedic Surgery	☐ Other _____

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: Weight: Color:

PET OWNER'S NAME AND CONTACT INFORMATION

Name:

Address/State/Zip:

Home Tel: Work Tel: Mobile Tel:

Email:

PATIENT CASE HISTORY

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 ( ) Radiographs ( ) ECG
( ) Other medical records (please specify)

REFERRAL INSTRUCTIONS

VETERINARIANS: When referring your patient to Veterinary Surgery Service, please complete this form prior to referral. You may FAX the completed form to 888-654-3567 or emailed to: surgery@surgeryvet.com along with any pertinent medical records.