

Veterinary Referral Form		Date:	
Owner / Patient Information		Referring Veterinarian (rDVM)	
Patient Name		Veterinarian Name	
DOB/Age		Veterinary Clinic	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female Neutered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Address	<input type="checkbox"/>
Breed		Clinic Phone	<input type="checkbox"/>
Species	<input type="checkbox"/> Canine <input type="checkbox"/> Feline	Fax	<input type="checkbox"/>
Owner Name		E-mail	<input type="checkbox"/>
Owner Phone		<input type="checkbox"/> <i>Select preferred correspondence</i>	
Client Number			
<input type="checkbox"/> Allergy for any medication, please specify:			

Referral Service Request		<input type="checkbox"/> Special Arrangements Necessary <i>Our Referral Coordinator will contact you to facilitate any special needs for your patient and client</i> EMERGENCY 24/7/365 <i>*A completed referral form is NOT required for access to our emergency department</i>
<input type="checkbox"/> Cardiology <input type="checkbox"/> Dentistry / Oral Surgery <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Oncology <input type="checkbox"/> Others, please specify: _____	<input type="checkbox"/> Critical Care <input type="checkbox"/> Dermatology <input type="checkbox"/> Neurology <input type="checkbox"/> Surgery	

Reason for request *Please tell us why you are seeking this consultation*

History of Present Illness *Please include clinical signs, and their onset, duration or progression, and severity.*

Summary of clinical findings *Please include date(s) and pertinent results. Please send lab reports and imaging.*

Current Treatments *Please include any current or previous treatments associated with this illness and response*

Specific Questions, Comments or Concerns, and Special Arrangements Details

Remarks: Indicate pertinent records submitted for review: Please send to referrals@cityuvmc.com.hk

Case Summary	Pertinent Medical History	Imaging (with interpretation) <input type="checkbox"/> Other:
<input type="checkbox"/> Yes	<input type="checkbox"/> Medical Notes <input type="checkbox"/> Histology Report	<input type="checkbox"/> Radiographs
<input type="checkbox"/> No	<input type="checkbox"/> Lab Results <input type="checkbox"/> Cytology Report	<input type="checkbox"/> Ultrasound

Fast your pet, no food for 12 hours and no drinks for 3 hours prior to appointment.