

# REFERRAL FORM



## DEPARTMENT REQUESTED:

Surgery  Internal Medicine  Dermatology  Ophthalmology  Rehabilitation

**PRIORITY:** URGENT  NON-URGENT

Client Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patients Name: \_\_\_\_\_ Species/Breed: \_\_\_\_\_

Age/DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Precautions: \_\_\_\_\_

RDVM Clinic: \_\_\_\_\_ RDVM on case: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Problems/Diagnostics: \_\_\_\_\_

Summary of Patient's History: \_\_\_\_\_

Clinical Findings: \_\_\_\_\_

Lab Results: \_\_\_\_\_

Current Therapies: \_\_\_\_\_

Etc: \_\_\_\_\_

Recent Bloodwork? YES  NO

Recent Radiographs? YES  NO

Recent Cytology? YES  NO

Recent Ultrasound? YES  NO

Recent Urinalysis? YES  NO

Imaging Report? YES  NO

*For expedited service please attach and send all of the above diagnostics including chart notes to: [xrays@ovra.com](mailto:xrays@ovra.com)*