

REFERRAL FORM



DEPARTMENT REQUESTED:

Surgery ☐ Internal Medicine ☐ Dermatology ☐ Ophthalmology ☐ Rehabilitation ☐ Oncology ☐

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 Cytology? YES ☐ NO ☐

Recent Urinalysis? YES ☐ NO ☐

Recent Radiographs? YES ☐ NO ☐

Recent Ultrasound? 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