Maryland Veterinary Surgical Services

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# SURGICAL REFERRAL FORM

DATE: _____

REFERRING DOCTOR: _____

REFERRING HOSPITAL: _____

CLIENT: _____

PATIENT: _____

AGE: _____ BREED: _____ GENDER: _____ WEIGHT: _____ lbs

HISTORY:_____

_____

_____

DIAGNOSIS: _____

PERTINENT MEDICAL HISTORY: _____

_____

_____

MEDICATIONS: _____

_____

_____

DIAGNOSTIC TEST RESULTS: _____

_____

_____

BLOOD WORK: _____

_____

_____

RADIOGRAPHS: _____

_____

_____

SPECIAL REQUESTS OR CONCERNS: _____

_____

_____

NOTE: please attach copies of recent blood work, histopathology and medical records. Please have the client bring the radiographs for the appointment. The radiographs will be given to the client at the time of discharge for return to your clinic.

Thank you for the opportunity to assist with the surgical needs of your client and patient. Please feel free to call should you have any additional questions or concerns.