



PATIENT REFERRAL

CLIENT Name _____ Phone _____
Last First M.I.

Address _____
Street City State Zip

PATIENT Name _____ Breed _____ Color _____ Sex _____ Age _____

MEDICAL HISTORY

Vaccinations:

Type: _____ Date: _____ Type: _____ Date: _____

Surgery (Tumors, Neuter, etc.) _____

Presented to our hospital on (Date) _____

Symptom or Problem _____ **Duration of condition** _____

Tentative Diagnosis _____

Lab Results (Dates) _____

Treatment Schedule _____

Present Condition _____

Remarks or Requests _____

Referring Veterinarian: _____ **Hospital:** _____

Address: _____ **Phone:** _____ **Fax:** _____

Dear client: Your doctor is referring you to VCVRC for further investigation into your pet's problem. In order to avoid duplication of work and expense bring X-rays and copy of any diagnostic test which may have been performed. Since you will return to your own veterinarian after resolution of this problem, we will send your doctor a letter detailing the events of your pet's visit so that your records may be kept up to date at your own hospital.

SURGERY

Carlos C. Hodges, D.V.M., M.S., P.C.
Practice Limited to Surgery
Salvador Galindo, D.V.M.
Practice Limited to Surgery

INTERNAL MEDICINE

Ronald D. Hodges, D.V.M., PC
Diplomate, ACVIM
Candace D. Carter, D.V.M.
Diplomate, ACVIM

CARDIOLOGY

Dennis E. Burkett, V.M.D., Ph.D
Diplomate ACVECC, ACVIM
Ellen T. Davision. V.M.D., Ph.D
Diplomate, ACVIM

OPHTHALMOLOGY

Robert L. Peiffer, D.V.M., Ph.D
Diplomate ACVO
Mary Landis, V.M.D., M.A.
Resident in Ophthalmology

NUCLEAR MEDICINE

Ronald D. Hodges, D.V.M., P.C.
Diplomate, ACVIM

DERMATOLOGY

Brian Palmeiro, V.M.D.
Diplomate, ACVD
Kevin Shanley, D.V.M.
Diplomate, ACVD