REFERRAL FORM

525 South Street Walpole, MA 02081
Phone 508.668.5454 Fax 508.850.9809
www.tuftsvets.org

Appointment Date/Time: _____

Referring to: ☐ *Emergency/Critical Care* ☐ *Internal Medicine* ☐ *Dermatology* ☐ *Cardiology*

☐ *Ophthalmology* ☐ *Surgery* ☐ *Dentistry* ☐ *Radiology*

OWNER INFORMATION
Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone (_____) _____-_____

PATIENT INFORMATION
Pet's Name: _____ Species: Canine Feline Other _____
Breed: _____ Age/D.O.B.: _____ Gender: F FS M MN

CASE HISTORY

Chief Concern/Provisional Diagnosis: _____
_____

History (please include vaccinations): _____
_____
_____
_____
_____
_____

Diagnostic tests performed (please attach results): _____
_____

Are radiographs included? Yes No

Current Therapy & Medications (include dosages): _____
_____
_____

Special Requests/Comments: _____
_____
_____

REFERRING VETERINARIAN INFORMATION

Name: _____ Clinic/Hospital: _____

Phone: (____) ____-_____ Fax: (____) ____-_____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

All contact information will be kept confidential