



# 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\*\***