



REFERRAL FORM

(Appointment Date/Time: _____)

Referring to: *Emergency/Critical Care* *Internal Medicine* *Ophthalmology* *Surgery*

OWNER INFORMATION

Name: _____ Daytime Phone: (____) _____ Evening Phone: (____) _____

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

PATIENT INFORMATION

Pet's Name: _____ Species: Canine Feline Other _____

Breed: _____ Age/Date of Birth: _____ Sex: M M/C F F/S

CASE HISTORY

Chief Concern/Provisional Diagnosis: _____

History: _____

Diagnostic Test Results (if possible, please attach results): _____

Current Therapy & Medication (include dosages): _____

Special Comments/Requests: _____

REFERRING VETERINARIAN INFORMATION

Name: _____ Clinic/Hospital: _____

Phone: (____) _____ Fax: (____) _____

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

Email: _____

All contact information will be kept confidential.

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