



Roman S. Savicky, DVM
Diplomate, American College of Veterinary Surgeons – Small Animal

Surgery Referral Form

Please email completed form and any diagnostics to: info@pvssaz.com

Requested Procedure: Left / Right / Bilateral / NA: _____

Requested Date(s): _____

HOSPITAL INFORMATION

Hospital: _____ Phone Number: _____

Attending Clinician: _____ Preferred Email Contact: _____

OWNER & PET INFORMATION

Owner: _____ Phone Number: _____

Pet Name: _____ Owner Email Address: _____

Age: _____ MI- FI- MC- FS- Weight (note lbs/kgs): _____ Breed: _____

Co-Morbidities: _____

Current Medications and Dosing/Frequency:

Yes / No: Blood Work Completed Within 4 Weeks of Surgery? _____

Yes / No: Radiographs Completed Within 4 Weeks of Surgery? _____

Pertinent Patient History: