Surgery Referral Form

Appointment Type Requested (Consult, Surgery, Recheck, Other): ______________________

Requested Procedure (please indicate side if applicable): ______________________

Requested Date(s): ______________

HOSPITAL INFORMATION

Hospital: ______________________

Phone Number: ______________________

Attending Clinician: ______________________

Preferred Email Contact: ______________________

OWNER & PET INFORMATION

Owner: ______________________ Phone Number: ______________

Owner Email Address: ______________________

Pet Name: ______________ Age: ________ Sex (intact status): ________

Species and Breed: ______________ Weight (note lbs/kgs): ________

Co-Morbidities: ______________________

Current Medications and Dosing/Frequency:

☐ Yes / ☐ No: Blood Work Competed (please attach/send)

☐ Yes / ☐ No: Radiographs Completed (please attach link/send)

Pertinent Patient History:

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