PEAK
VETERINARY SURGICAL SOLUTIONS

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

ACVS VETERINARY SURGEON

Surgery Referral Form

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

Appointment Requested (Consult, Surgery, Other): _____ **Requested Date(s):** _____

Requested Procedure: ☐ **Left /** ☐ **Right /** ☐ **NA** _____

☐ **Yes /** ☐ **No: Request for PEAK Veterinary Surgical Solutions to plan and monitor anesthesia (additional charges apply)**

HOSPITAL INFORMATION

Hospital: _____ **Phone Number:** _____

Attending Clinician: _____ **Preferred Email Contact:** _____

OWNER & PET INFORMATION

Owner: _____ **Phone Number:** _____

Pet Name: _____ **Owner Email Address:** _____

Age: _____ **Sex (intact status):** _____ **Weight (note lbs/kgs):** _____ **Species and Breed:** _____

Co-Morbidities: _____

Current Medications and Dosing/Frequency:

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

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

Pertinent Patient History: