



VETERINARY SURGICAL SOLUTIONS

Surgery Referral Form

Appointment Type Requested (Consult, Surgery, Other): _____

Requested Procedure (MUST 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 Completed (please attach/send)

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

Pertinent Patient History:

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