# Patient Referral Form

All pets treated at South Texas Veterinary Surgery must have a referral.

## Veterinarian Information

_____ Referring Veterinarian

_____ Hospital Name

How do you prefer your records?

☐ Email
☐ Fax
☐ Both

_____ Hospital Email

_____ Hospital Phone

_____ Hospital Fax

## Patient Information

_____ Patient Name

_____ Age/Birthdate

_____ Breed

☐ Canine ☐ Feline ☐ Male ☐ Female ☐ Neutered ☐ Spayed

## Client Information

_____ Client Name

_____ Client Phone

_____ Alternate Client Phone

_____ Client Email

_____ Client Address

**Please fill out the following information regarding the patient's evaluation and diagnosis:**

Diagnosis: _____

Referral Status:

- ☐ Emergency
- ☐ Elective

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Diagnostics already performed (check all that apply):

- ☐ Cytology/FNA
- ☐ Histopathology
- ☐ Surgery/excision
- ☐ Bloodwork/UA
- ☐ Radiographs
- ☐ Ultrasound
- ☐ CT scan
- ☐ MRI

How can we fulfill the expectations for you and your client? (check all that apply)

- ☐ Consultation only
- ☐ Consultation and Surgery
- ☐ Other_____

**Please email this form along with all medical records, test results, and images to STVSpets@gmail.com**

Thank you for your referral. Once this is received, the STVS reception team will reach out to your client to schedule a consultation.

Please contact our staff with any questions or concerns for your patients and clients.

**STVSPets.com**

STVS
SOUTH TEXAS
VETERINARY SURGERY

**210-962-5388**