# EXPECTATIONS FOR THIS CASE:

**PATIENT**

**REFERRAL FORM**

102 Magill Road, Norwood | Ph: 08 8132 0533 Fax: 08 8132 0633 [reception@vetreferrals.com.au](mailto:reception@vetreferrals.com.au) | [**www.vetreferrals.com.au**](http://www.vetreferrals.com.au/)

Date:

Consult Only. Please direct the patient back to my office for diagnostic testing and treatment.

Please manage diagnostic testing and treatment at AVSARC.

*\*mandatory fields*

# REFERRING VETERINARIAN

Dr. Name: Vet Hospital/Clinic: Phone: Fax: Email:

How would you like to be contacted for this case?

email phone fax other

# CLIENT DETAILS

Name: Address: Phone: Work: Mobile 1: Mobile 2: Email:

# PATIENT DETAILS

Name: Age: Sex: M F

Breed/Species: Desexed: Y N

Please select one:

**EMERGENCY**

*(please call AVSARC)*

Condition is life threatening, must be seen immediately

**URGENT**

Patient is stable, but may decline without acute attention

**ROUTINE**

Soonest available appointment

# REFERRAL TO:

**Surgery**

Next available appointment Dr. Andrew Dunn

Dr. Ryan Taggart

**Dermatology**

Dr. Andrew Carter

**Internal Medicine**

Dr. David Davies

**Physiotherapy**

Emma Kirby

**Radioactive Iodine Therapy**

Dr. David Davies

Weight:

Is the patient insured? Y N

# REASON FOR REFERRAL

Please select and attach the relevant medical information appropriate for your patient and for this referral case. For Diagnostic Imaging DICOM format is preferred along with original and full copies of written radiology reports. For Laboratory Results, please provide the original and full copies. To submit this medical information you can visit our website and upload via the Dropbox link, email [reception@vetreferrals.](mailto:reception@vetreferrals.com.au) [com.au](mailto:reception@vetreferrals.com.au) or fax to 08 8132 0633.

# MEDICAL RECORDS

**DIAGNOSTIC IMAGING**

**LABORATORY RESULTS**

Patient history

Radiographs

Ultrasound CT

MRI

Bloodwork

Urinalysis Cytology

Histology

Culture Other