PATIENT REFERRAL FORM

102 Magill Road, Norwood | Ph: 08 8132 0533 Fax: 08 8132 0633
reception@vetreferrals.com.au | **www.vetreferrals.com.au**

ADELAIDE VETERINARY
SPECIALIST & REFERRAL CENTRE

Date: _____

EXPECTATIONS FOR THIS CASE:

☐ Consult and diagnostic procedure only. Please direct the patient back to my office for treatment.

☐ Please manage diagnostic procedures 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

Weight: _____ Is the patient insured? ☐ 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**
☐ **Dermatology**
☐ **Internal Medicine**
☐ **Physiotherapy**
☐ **Diagnostic procedures**

*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.com.au or fax to 08 8132 0633.

MEDICAL RECORDS

☐ Patient history

DIAGNOSTIC IMAGING

☐ Radiographs
☐ Ultrasound
☐ CT
☐ MRI

LABORATORY RESULTS

☐ Bloodwork
☐ Urinalysis
☐ Cytology
☐ Histology
☐ Culture
☐ Other