REFERRAL FORM

Today's date:

Referring Veterinarian Information

Name: Hospital:

Address:

Phone: Fax: Email:

Preferred Method of Receiving Information from AADS: Fax ☐ Email ☐

A visit summary will be sent to you within 24-48 hours of your patient's appointment.

Client Information

Name: Phone(s):

Address:

Patient Information:

Pet's Name: Breed: Sex:

Date of Birth/Age: Weight: Is this an emergency case? Yes ☐ No ☐

Is or has this pet become aggressive in your office? Yes ☐ No ☐

Has this pet experience any adverse reactions or problems during anesthesia or with sedation?

Yes ☐ No ☐ If yes, please explain:

Has this pet had any adverse allergic reactions to medications, topicals, or vaccines?

Yes ☐ No ☐ If yes, please explain:

Other Medical or Surgical Problems:

Reason for Referral:

Current or Most Recent Medications:

Summary of Dermatological History:

Additional Comments/Special Requests:

Please fax a <u>complete medical history</u> with all previous labwork (including blood/serum allergy testing) to (702) 644-9261.