

REFERRAL REQUEST FORM

Please provide all the details we will need to help us provide you the best advice, and to allow us to make the necessary arrangements directly with the owner if required.

Which referral service(s) do you require? Orthopaedics Soft tissue surgery

Please indicate:

Telephone consultation only (please note: a fee may be charged for telephone advice)

Urgent (call back within 4 hours) Non-urgent (call back within 24 hours)

Please call referring Veterinary Surgeon first Please contact owner directly

Practice name: _____

Referring Veterinary Surgeon: _____

Practice address: _____

Telephone: _____ Facsimile: _____

Email address: _____

Alternate contact number: _____

Owners name: _____

Address: _____

Telephone _____ Mobile _____

Email address: _____

Pets name: _____ Cat Dog Other _____

Breed: _____ Sex: M/F Neutered Y/N Age: _____

Previous tests performed: Laboratory tests Radiographs Other:

Please provide copies of relevant lab results. Digital clinical notes and x-rays can be submitted directly to admin@vetspecs.co.nz

****Continued overleaf...**

90 Disraeli St, Addington, Christchurch

Phone: 03 341 6449

Fax: 03 341 6450

Email: admin@vetspecs.co.nz



vetspecs

Veterinary Specialists

Please provide a thorough clinical history (including current therapy):
Attach notes if required