



Patient Referral Form

(Please check desired services)

- Surgery Radiograph Review
 Outpatient CT

PRIMARY VETERINARIAN INFORMATION

Date:	
Name:	Hospital:
Email:	Phone:

CLIENT INFORMATION

Name:	
Address:	City/State/Zip:
Home phone:	Work phone:

PATIENT INFORMATION

Name:	Species	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline
Breed:	Color:	DOB:	Weight:
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Male-neutered <input type="checkbox"/> Female <input type="checkbox"/> Female-spayed		
Vaccination status:	<input type="checkbox"/> Current <input type="checkbox"/> Unknown <input type="checkbox"/> Not current (clarify):		
Previous history of medical problems:			
Reason for referral:			
Previous Lab data/radiographs:			
Tentative diagnosis:			
Check if you would like to receive: <input type="checkbox"/> Brochures <input type="checkbox"/> Referral pads			

Radiograph review fees:
\$60.00 - up to 5 images, \$80.00 - 6-12 images, \$100.00 - 13+ images
Please call for image transfer instructions.

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RADIOLOGY: Anthony J. Fischetti DVM, MS, DACVR | **ADMINISTRATOR:** Kathleen Moran, BA, CVPM

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