6675 E. Waterloo Rd.
Edmond, OK 73034

Small Animal Referral Form

(405) 341-9350
Fax: (405) 359-2869

Referral Hospital: _____ **Primary Doctor:** _____

Hospital Phone: _____ Hospital Fax: _____

OWNER NAME: _____ Client Phone: _____

Client Address: _____ Secondary Phone: _____

City: _____ State: _____ Zip: _____

PATIENT NAME: _____ Canine ☐ Feline ☐ Other: _____

Male ☐ Female ☐ Spayed/Neutered? ☐

Breed: _____ Age: _____ Weight: _____ **Aggressive?** Yes ☐ No ☐

SPECIFIC AREA TO BE EVALUATED: _____

History/Clinical Signs: _____

_____

_____

_____

Preliminary Diagnosis: _____

All Current Medications: _____

Please include copies of any recent sedation/anesthetic events along with current bloodwork.

Has this patient ever had an adverse drug reaction? Yes ☐ No ☐

If yes, please attach an explanation.

Special Care Instructions: _____

Permission for General Anesthesia? Yes ☐ No ☐

Are we authorized to perform resuscitation measures if required? Yes ☐ No ☐

Does this patient require special anesthetic considerations? Yes ☐ No ☐

Would you like a copy of the MR images on a CD? Yes ☐ No ☐

REFERRAL POLICY: Patients referred by veterinarians will receive services related to the presenting problem only. Clients are requested to return to their referring veterinarian for all other services.
PERMISSION TO SCAN is granted by the signer below as representative of the referring hospital, or as the patient's owner.

Signature: _____ **Date:** _____