

Please send to referral@hvoc.com.hk

Referral Date: _____

Veterinary Referral Form

Owner Information

Owner Name _____
 Owner Tel. _____
 Client Number _____

Referring Veterinarian (rDVM)

Veterinarian Name _____
 Veterinary Clinic _____
 Clinic Phone _____
 Fax _____
 E-mail _____
 Address _____

Patient Information

Patient Name _____
 Date of Birth/Age _____
 Sex M F Neutered Y N
 Breed _____
 Species Canine Feline Others

Referral Service

Cardiology Critical Care Dentistry and Oral Surgery Medical Oncology Orthopedic Surgery
 Pain Management Radiation Oncology Soft Tissue Surgery Others:
Special Arrangements Necessary, Others (please specify):

Reason for Request *Please tell us why you are seeking this consultation.*

History of Present Illness *Please include clinical signs, and their onset, duration or progression, and severity.*

Summary of Clinical Findings *Please include date(s) and pertinent results. Please also send lab reports and imaging.*

Current Treatments *Please include any current or previous treatments associated with this illness and response.*

Specific Questions, Comments or Concerns, and Special Arrangements Details.

Remarks: Indicate pertinent records submitted for review. Please send to referral@hvoc.com.hk

Case Summary

Yes
 No

Pertinent Medical History

Medical Notes Histology Report
 Lab Results Cytology Report

Imaging (with interpretation)

Radiographs CT Scan Report **Others:**
 Ultrasound MRI Scan Report