

REFERRAL FORM



Dermatology Center for Animals

430 Yale Avenue North • Seattle, WA 98109
Tel 206 508-5500 • Fax 206 508-5520

Patient Name: _____

Species: _____ Breed: _____

Sex: _____ Age: _____

Weight: _____ Color: _____

PLEASE CHECK IF YOU WOULD LIKE DCA TO CONTACT CLIENT FOR APPOINTMENT.

Patient Owner: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS AND LAB RESULTS

Reason for Referral: _____

Vaccination / FeLV / FIV Status: _____

Animal Temperament: _____

Pertinent History: _____

Pertinent Lab Results: *(Please send a complete copy of results and reference ranges)* _____

Current Medication / Treatment: _____

Estimate Given: YES NO

\$ _____

Referring Veterinarian: _____

Veterinary Clinic: _____

Address: _____

Phone: _____

Email: _____

Fax: _____

PREFERRED COMMUNICATION OPTIONS

LETTER FAXED

PHONE CALL

EMAIL

TO BE COMPLETED BY REFERRING VETERINARIAN AND MAY BE FAXED OR PRESENTED AT TIME OF APPOINTMENT
COMPLETION AND SUBMISSION WILL INSURE YOU RECEIVE A FOLLOW UP REPORT ON THIS PATIENT