



Circle City Veterinary Specialty & Emergency Hospital

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ONCOLOGY REFERRAL FORM

Attention to referring veterinarian: Please complete the following information regarding your patient and fax, mail, *or* send with your client for their first appointment.

Date _____

CLIENT:

Name _____

Address _____

City _____ State ____ Zip Code _____

Referring Veterinarian _____

Address _____

Phone _____

Reason for referral _____

PATIENT:

Name _____ Species _____

Breed _____ Sex ____ DOB _____

Vaccinations current: Yes__ Date Given _____ No__

Is this animal known to be aggressive? Yes ____ No ____

Hospital/Clinic Name _____

City _____ State ____ Zip Code _____

Fax _____ Email _____

History, clinical signs, laboratory findings _____

Tentative diagnosis _____

Patient's overall condition: Good__ Fair__ Poor__ Lab work: Yes__ No__ Radiographs: Yes__ No__

Current Therapy _____

Medication _____ Date _____ Dose/Frequency _____ Response _____

Please send along with this form all previous diagnostic test results.

Comments _____

Please remember to include complete copies of your patient's medical records and lab results.

A summary of each visit will be forwarded to you and your client. Inquiries, comments, and suggestions are always welcome. Thank you for your referral.

12/23/2008