



Veterinarian Referral Form

DATE: _____

Please mark status of appointment: Immediately This Week Non-Emergency

Please mark the service needed for the patient below:

Please fax completed form to (832) 900-3970 or submit via email to info@gcvcs.com. For Neurology & Neurosurgery referrals, please email completed form to neuroinfo@gcvcs.com.	
<p>3800 Southwest Freeway Location</p> <p><input type="checkbox"/> Neurology & Neurosurgery*</p> <p><input type="checkbox"/> Avian & Exotics*</p> <p><input type="checkbox"/> Diagnostic Imaging (CT or MRI)**</p> <p>Specified Doctor (optional): _____</p> <p>_____ *For questions call (713) 341-9520 **For questions call (713) 693-1111</p>	<p>1030 Wirt Rd Location</p> <p><input type="checkbox"/> Critical Care (<i>Referrals MUST be called in to (713) 693-1111</i>)</p> <p><input type="checkbox"/> Cardiology</p> <p><input type="checkbox"/> Dentistry & Oral Surgery</p> <p><input type="checkbox"/> Dermatology & Allergy</p> <p><input type="checkbox"/> Diagnostic Imaging (Ultrasound)</p> <p><input type="checkbox"/> Emergency</p> <p><input type="checkbox"/> Rehabilitation & Fitness (<i>See required signature in form below</i>)</p> <p>Specified Doctor (optional): _____</p> <p>For questions call (713) 693-1111</p> <p><input type="checkbox"/> Internal Medicine</p> <p><input type="checkbox"/> Ophthalmology</p> <p><input type="checkbox"/> Medical Oncology</p> <p><input type="checkbox"/> Nutrition</p> <p><input type="checkbox"/> Surgery & Orthopedics</p>

REFERRING DR: _____ CLINIC NAME: _____

PHONE: _____ FAX: _____

EMAIL: _____

CLIENT/PATIENT INFORMATION

OWNER NAME: _____ CO-OWNER: _____

PHONE (H): _____ (W): _____ (C): _____

PET NAME: _____ BREED: _____

SEX: Male Neutered Female Spayed Age/DOB: _____ Weight: _____ Fractious: Yes No

MEDICAL RECORDS, PERTINENT LABWORK AND RADIOGRAPHS

Have radiographs been taken? Yes No Date of study: _____

Have medical records, lab work, and/or radiographs: Been Faxed E-Mailed Owner Bringing

Brief History & Primary Complaint: _____

Is the patient potentially infectious? Yes No

Tentative Diagnosis: _____

→ Please send current lab work, biopsy reports, and medical records with this form.

→ Please email, fax or send copies of radiographs with the owner.

Rehabilitation and Fitness: <i>As the attending veterinarian, I have determined that rehabilitation will not likely be harmful to the patient.</i>	
_____ Referring Veterinarian's Signature	_____ Date