THE ONCOLOGY SERVICE

Referral Form

TOS - RICHMOND | 804-999-0001 | 5711 Staples Mill Road, Suite 102

PLEASE SUBMIT RECORDS AND THIS COMPLETED FORM TO:

Email: tosrichmond@ethosvet.com | FAX: 804-482-2763

CLIENT AND PATIENT INFORMATION: *(please fill out on behalf of the client)*

Client Name: _____ **Preferred Phone:** _____

◯ Home ◯ Cell ◯ Work

Patient Name: _____

Date of Birth: _____

Breed: _____ **Species :** ◯ Canine ◯ Feline **Sex:** ◯ Neutered Male ◯ Intact Male ◯ Spayed Female ◯ Intact Female

MEDICAL INFORMATION

Note: Please forward all pertinent medical record information including results of laboratory tests by fax or email. This allows our staff to review details of the case prior to the appointment and provide optimal patient care and client service. Radiographs and additional copies of the record may be emailed or sent with the client on the day of the appointment.

Diagnosis *(if applicable)*: _____

History: *(signs, onset, progression)* _____

Vaccination History: _____

Current Diet: _____ **Weight:** _____ **Body Condition:** ____ **/ 9**
(if prescribed)

Diagnostics Performed: *(please attach test results)*

◯ Cytology ◯ Histopathology ◯ Radiographs ◯ CBC ◯ Chemistry
◯ Urinalysis ◯ Surgery ◯ Ultrasound ◯ CT ◯ MRI

Current Medications: *(include dosage, duration, response)* _____

Has the Patient Seen Other Specialists? *(Please list)*: _____

REFERRING VETERINARIAN INFORMATION:

Referring Veterinarian: _____

Referring Veterinary Hospital: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Signature: _____ **Date:** _____