VETDERM
ALLERGY, EARS, & SKIN SPECIALISTS

Patient Referral Form

Date of Referral _____

OWNER INFORMATION:

Owner Name(s) _____

Primary Phone Number _____ Alternate Phone Number _____

Contact E-mail _____

Address _____ City _____ Postal Code _____

REFERRING VETERINARIAN INFORMATION:

Doctor Name_____ Clinic Name _____

Phone Number _____ Fax Number _____

Contact E-mail _____

Desired Method of Referral Report Delivery: ❑ Fax ❑ Email

STATUS OF REFERRAL ❑Non-urgent ❑ Urgent ❑ Emergency

PATIENT INFORMATION:

Patient Name_____ Species_____

Breed_____ Sex _____

Date of Birth_____ Vaccination Status_____

Anesthetic Risk_____ Cardiac status_____

Heart Murmur / Grade ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑None

Non-dermatological conditions / disease_____

Temperament_____

FAS Score ❑0 Relaxed ❑1 Mild ❑2-3 Moderate ❑4 Severe (flight, freeze, fret) ❑5 Severe (fight/aggression)

Is anti anxiety medication needed or been prescribed for veterinary visits?_____

**Please note, pre-visit pharmaceuticals including Gabapentin and Trazodone, do not interfere with dermatology assessment or allergy testing. If the patient requires anti anxiety medication for examination, please provide to client prior to the initial consultation.*

healing is a team effort

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e. info@vetdermclinic.com
w. vetdermclinic.com

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Primary Reason for Patient Referral:

Case Summary:

Medications / Treatments and Response to therapy:

Diagnostics (Please attach any diagnostic or laboratory reports):

Special Requests or Expectations:

Thank you for your referral.
We appreciate your time and effort in filling out this information.
Your client will be contacted shortly to schedule an appointment.

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