

Client and Pet Information

Client name:

Home address:

City:

State:

Zip:

Home phone:

Cell phone:

Alternate phone:

Email:

Pet Name:

Species:

Dog

Cat

Breed:

Color:

Sex:

Female

Male

Spayed/Neutered?

DOB or age:

Referral Veterinarian

Veterinary Clinic:

Referring Veterinarian:

Clinic address:

Phone:

Fax Number:

Email:

Patient Case History

Department Requested:

Acupuncture

Cardiology

Internal Medicine

Oncology

Surgery

Reason for referral (chief complaint):

Medical History/ Clinical signs:

Diagnostics and Procedures:

Current medications/ therapies:

Differential Diagnosis:

Referral Instructions

Form can be faxed to (717) 344-5548 or emailed to info@lancastervs.com

We request 2 years of medical records be sent along with this referral form prior to the appointment. Records should include lab work and radiographs when applicable.