Lancaster Veterinary Specialties

Patient Referral Form

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 □ Ophthalmology □ 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.

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