VETERINARY SPECIALTY CENTER of Seattle

Patient Referral Form

20115 44th Ave. West, Lynnwood, WA 98036
Office (425) 697-6106
Fax (425) 697-4746

OPEN 24/7/365

Referring Veterinarian

Referring Veterinarian Name_____ Phone_____

Practice Name_____ Fax _____

Preferred Method Of Communication: ☐ Fax ☐ Phone ☐ Email (Address) _____

Referred Patient and Client

Last Name _____First Name _____Patient Name _____

Species: ☐ Canine ☐ Feline Sex: ☐ Male ☐ Female ☐ Altered Breed: _____ Age: _____

Current Food/Diet: _____ Allergies: _____

Vaccination Status: ☐ All Are Current ☐ Current On Rabies Only ☐ All Are Overdue ☐ Unknown

Reason For Referral_____

Immediate History_____

_____

Tentative Diagnosis_____

Current Medications

Medication	Dosage and Route Of Administration	Last Given
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Other Information/Comments: _____

_____

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_____

Transfer Patient Back To Regular Veterinarian: ☐ Yes (Time Desired: _____) ☐ No