Veterinary Dermatology Center

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DATE_____ **REFERRAL FORM**

REFERRING VETERINARIAN:_____ OWNER'S NAME:_____

HOSPITAL:_____ PET'S NAME:_____

ADDRESS:_____ SPECIES:_____ BREED:_____

_____ SEX:_____ AGE:_____ WEIGHT:_____

HOSP. PHONE:_____ SPECIAL CARE NECESSARY? (i.e. muzzle?)_____

FAX_____ _____

E-MAIL_____ APPT DATE (IF KNOWN)_____

HISTORY:_____

CLINICAL SIGNS:_____

PREVIOUS LAB WORK (PLEASE ATTACH COPIES):_____

CLINICAL DIAGNOSIS:_____

PREVIOUS TREATMENT:_____

COMMENTS (CONTINUE ON BACK):_____