Cascade Veterinary Specialists

Referral Data Form

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660 NW Gilman Blvd, Suite C-2, Issaquah, WA Phone: 425-391-5015 Fax: 425-391-4916

If possible, the patient should be presented after an 8 to 12 hour fast.

Date of referral:_____

Referring Veterinarian:_____Clinic/Hospital Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: (_____)_____-_____ Fax: (_____)_____-_____ Email: _____

Owner's Name:_____ Spouse/Co-owner (s): _____
Address:_____ City:_____ State:_____ Zip:_____
Home: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

Patient's Name: _____ Species_____ Sex: ☐ Male ☐ Neutered ☐ Female ☐ Spayed
Age: _____ Color: _____Breed:_____

Tentative Diagnosis / Primary Complaint:
_____
_____
_____

Pertinent Medical History: _____
_____
_____
_____
_____
_____
_____

Medication History (dates & dosages):_____
_____
_____
_____
_____

Clinical Pathology History **(Please send copies and include lab normals)**: _____
_____

Other Testing (ECG, Radiographs, Ultrasounds, CT/MRI):
If radiographs were taken, please send them with the client or via courier if time allows.
_____
_____
_____

_____

Signature of Referring Veterinarian