

Referral Request



Referring vet name & address

Tel:.....
Fax:.....

(Please fax back to **01823 652822** or email info@cave-vet-specialists.co.uk)

Urgent

Routine

Emergency (If emergency please also call **01823 653510**)

Client Details

Name:.....(Mr/Mrs/Ms)
Address:.....
.....
.....
.....
Post Code:
Tel:.....

Patient Details

Name:.....
Species:.....
Breed:.....
Age:.....Sex:.....Neutered: Y/N
Fully Vaccinated: Y/N
Up to date worming : Y/N
Insured : Y/N Company :.....

Medicine **Oncology** **Neuro** **Ortho** **Soft Tissue** **Derm** **Pain Clinic**

Reason for referral please fill in box below –

We require the following to be sent to us –

- | | | | | |
|--|--------------------------------|-------------------------------|-------------------------------------|------------------------------|
| ➤ Radiographs - YES/NO | Email <input type="checkbox"/> | Post <input type="checkbox"/> | With Owner <input type="checkbox"/> | Fax <input type="checkbox"/> |
| ➤ Full History - | Email <input type="checkbox"/> | Post <input type="checkbox"/> | With Owner <input type="checkbox"/> | Fax <input type="checkbox"/> |
| ➤ Original Lab reports - | Email <input type="checkbox"/> | Post <input type="checkbox"/> | With Owner <input type="checkbox"/> | Fax <input type="checkbox"/> |
| ➤ <u>Covering Letter summarising the case .</u> | | | | |