



**VETERINARY  
EMERGENCY  
& SPECIALTY  
HOSPITAL OF WICHITA**

## SURGICAL & DENTAL REFERRAL FORM

Referring Veterinarian: \_\_\_\_\_ Referring Veterinary Clinic: \_\_\_\_\_

Referring Veterinary Clinic Telephone: \_\_\_\_\_ Referring Veterinary Clinic Fax: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_

Client Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_

Previous Medical History:

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Clinical/Physical Exam Findings:

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Diagnostic Findings:

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Tentative Diagnosis: \_\_\_\_\_

Current Treatment & Medications:

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Comments: \_\_\_\_\_

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