Stauffer Veterinary
SURGICAL CENTER

Surgery Referral Form

Please have your client call our office for an appointment. You may email or fax this form to our office.

Client: _____ Date: _____

Address: _____

City/State/Zip Code: _____

Phone Number(s): _____

E-Mail Address: _____

Patient: _____ Species: _____ Weight: _____

Breed: _____ Sex: _____

Date of Birth/Age: _____

Color: _____

Referring Veterinarian: _____

Hospital/Clinic Name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ Fax: _____

E-Mail Address: _____

Reason for referral: _____

History/Clinical Signs: _____

Tentative Diagnosis: _____

Current Medication List: _____

Lab Work: Yes No

Radiographs: Yes No

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