

NORTH DOWNS SPECIALIST REFERRALS

Fax-Back Appointment Request Form



Please Fax form to us on **01883 740154**

Please Note: We will contact the owners directly and make an appointment and fax a confirmation back to you.

Referring Veterinary Surgeon: _____

Referring Practice: _____

Telephone: _____ Fax: _____

Email: _____

Mr/Mrs/Miss/Other _____ Owner's Name: _____

Owner's Address: _____

_____ Postcode: _____

Postcode: _____ Email: _____

Contact Tel No.: (1) _____ (2) _____

Patient's Name: _____

Species: Canine/Feline Breed: _____

Age: _____ Sex: Male/Female Weight _____ Kg

CLINICAL PROBLEM: _____

REFERRAL SERVICE REQUIRED: Please tick one box

- | | | |
|--|--|--|
| <input type="checkbox"/> ORTHOPAEDICS | <input type="checkbox"/> SOFT TISSUE SURGERY | <input type="checkbox"/> INTERNAL MEDICINE |
| <input type="checkbox"/> OPHTHALMOLOGY | <input type="checkbox"/> NEUROLOGY/SPINAL SURGERY (inc. MRI) | |
| <input type="checkbox"/> ONCOLOGY | <input type="checkbox"/> CARDIOLOGY | <input type="checkbox"/> DERMATOLOGY |
| <input type="checkbox"/> OUTPATIENT ULTRASOUND (not cardiac) | | |

If you are unsure which service to refer a case to, please contact us to discuss.

INSURED FOR VETS FEES? YES/NO

- | | | |
|------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> EMERGENCY | <input type="checkbox"/> URGENT | <input type="checkbox"/> ROUTINE |
|------------------------------------|---------------------------------|----------------------------------|