

Registered veterinary practice name: _____

Address: _____ Postcode: _____

Telephone: _____ Fax: _____

Email: _____

Registered veterinary surgeon: _____

Animal Details

Name: _____

Breed: _____

Age/DoB: _____

Date of last vaccination: _____

Sex: Male Female Neutered

Clinical signs/Diagnosis:

Present Treatment/s:

Owner Details

Title: Mr Mrs Ms Miss

Initial/s: _____

Surname: _____

Address: _____

Postcode: _____

Tel home: _____

Tel work: _____

Tel mobile: _____

Email: _____

Do you suspect an Infectious Disease? Yes No

Recently acquired cough or sneeze? Yes No

Checklist

1. Any radiographs taken: Yes No Owners to bring Vet to email Vet to post

2. Previous Lab results taken at RVS? Yes No

3. Letter of Referral: Yes No Owners to bring Vet to email Vet to post

4. History: Owners to bring Vet to email Vet to post

5 Insurance: Yes No Company: _____

6. Advise vet/owner: Food to be withheld from midnight on the eve of the appt / no restriction on water

7. Treatment to be withdrawn? Yes No Days / Weeks prior

Appointment details: Clinical emergency as determined by referring practice

Emergency? Yes - within 24 hours Yes - within 3 days Chronic but within 2 weeks Not urgent

Service:

Acupuncture Behaviour Cardio Dermatology Internal Medicine Neuro Oncology

Ophthalmology Ortho Rehab/Pain Anaesthesia Radioactive Iodine STS

Additional notes: _____