



INTERNAL MEDICINE CONSULT REQUEST

Dr. Julie Armstrong

Referring Hospital & Veterinarian	DATE
Referring Veterinarian (print) ☆	<i>Referring Doctor Signature</i> ☆

IT IS IMPERATIVE THAT A COMPLETE MEDICAL RECORD IS RECEIVED AT LEAST 24HRS PRIOR TO APPOINTMENT. RECORD MAY BE SENT BY MAIL, FAX OR EMAIL. INCLUDE RADIOGRAPHS, ULTRASOUND REPORTS ETC.

CLIENT

Client Last Name		First Name	
Street Address	City	Postal Code	
Home Phone	Cellular	★ Email	

PATIENT

Name	Breed	Species	Sex M MN F FS	Age (MM / DD / YYYY)
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REASON FOR REFERRAL

Current Medical Concern(s)	
1.	3.
2.	4.
Relevant History, Comments or Special Concerns	
Past Procedures Performed (Radiographs, Ultrasound, Diagnostic Tests, Previous Consults) <i>*Please have client bring results of past procedures</i>	
Current Medications / OTC / Supplements	

Please be aware this is a consultation appointment only. All efforts will be provided to assist in coordinating the recommended diagnostics to be performed at BBVSH or your clinic. Note diagnostic capability at this time is not all encompassing.

Appointment Date	Appointment Time	Booked By
Appointment Reminder done on	Date	Time BBVSH staff