



SURGERY CONSULT REQUEST

Dr. Geoff Hutchinson

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

CLIENT

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

PATIENT

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

REASON FOR REFERRAL

Current Concern(s) Requiring Consultation
Relevant History, Comments, Special Concerns
Past Procedures Performed. (Radiographs, Ultrasound, Diagnostic Tests) <i>Please send radiographs with client.</i>
Current Treatment/Medications currently or previously given.

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