



TVS Referral Request

Veterinarian: _____

Hospital: _____ email: _____

Owner: _____

Contact: phone/email _____

Patient information:

Name: _____ Age: _____ M / F Spayed/Neutered

Reason for referral:

Referral Expectations:

Consultation, diagnostics, and treatment

Consultation only

Diagnostic imaging:

Ultrasound region of interest: _____

CT region of interest: _____

Diagnostics performed and available prior to referral:

Preferred contact:

Client call Veterinarian call

TVS will review the referral request above and contact you as soon as possible. Please contact us via phone at 520-261-8151 if you have not received a response within 2 hours during business hours. Email confirmation will be sent to referring hospital following client contact. Referrals submitted outside of business hours will be replied to the following morning.