TVS Referral Request

Veterinarian: _____

Hospital: _____ Email: _____

Owner: _____ Contact: phone/email _____

Patient information:

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

Neurology ☐ Valley Fever Center for Excellence ☐ Radiology ☐ Cardiology ☐

Reason for referral: _____

_____

_____

Referral Expectations:

Consultation, diagnostics, and treatment ☐

Consultation only ☐

Outpatient 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.