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 ☐ Internal Medicine ☐

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.