



Patient Referral Form

P: 206-204-3366

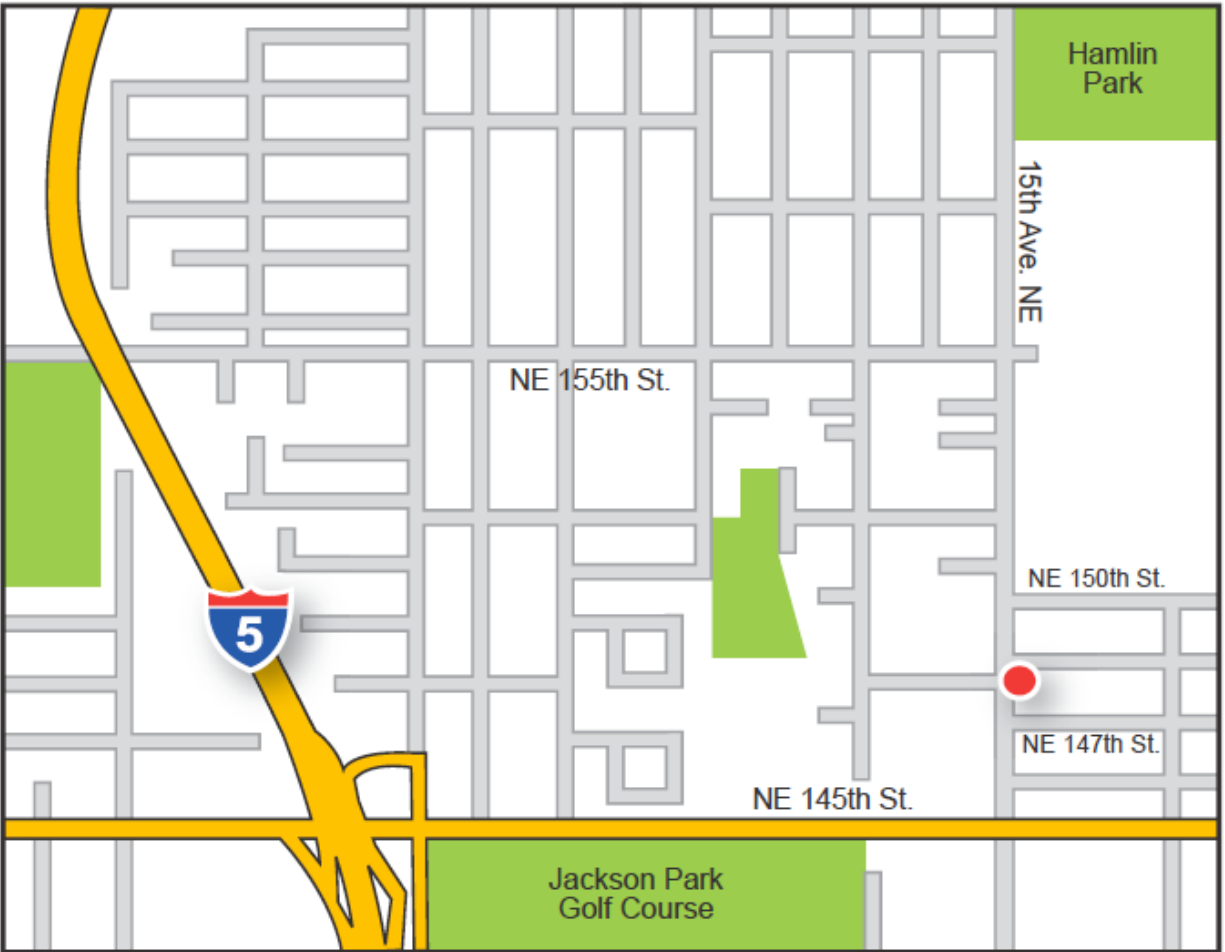
F: 206-204-3858

Referral form for Oncology

Client & Patient Information		Referring Doctor Information	
Client Name		Primary DVM	
Patient Name		Hospital	
Species		DVM Phone	
Breed, Age & Gender		DVM Fax	
Cancer Type & Location: _____			
Date of Diagnosis: _____			
Recurrent Tumor: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other health concerns: _____			
Diagnostics done prior to referral – please circle all that apply:			
<i>Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.</i>			
<i>Biopsy</i>	<i>FNA/ cytology</i>	<i>CBC</i>	<i>Serum Chemistry</i>
<i>MRI</i>	<i>Ultrasound</i>	<i>Lymph node aspirates</i>	<i>X-rays</i>
			<i>U/A</i>
			<i>CT scan</i>
			Other: _____
Any surgery other than spay? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, describe: _____			
Any known adverse reactions to medication or anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current medications and supplements:			
Brief Case Summary			

PLEASE HAVE YOUR CLIENT CALL US TO SCHEDULE AN APPOINTMENT WITH ONCOLOGY.

THANK YOU FOR YOUR REFERRAL. DIRECTIONS TO THE FACILITY ARE ON THE BACK OF THIS FORM.



From I-5 Northbound:

Take exit 175 toward **WA-523/NE 145th St**
Slight **left** at **5th Ave NE**
Take the 1st **right** onto **NE 145th St/WA-523 E**
Turn **left** at **15th Ave NE**
Destination will be on the right

From I-5 Southbound:

Take exit 175 for **WA-523/NE 145th St** toward **5th Ave NE**
Turn **left** at **NE 145th St/WA-523 E**
Turn **left** at **15th Ave NE**
Destination will be on the right

14810 15th Avenue NE, Suite B, Shoreline, WA 98155