Patient Referral Form

P: 206-204-3366
F: 206-204-3858

Referral form for Oncology

Animal Medical Center of Seattle

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: ☐ Yes ☐ No

Other health concerns: _____

Diagnostics done prior to referral – *please circle all that apply:*

Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.

Biopsy *FNA/ cytology* *CBC* *Serum Chemistry* *U/A* *CT scan*
MRI *Ultrasound* *Lymph node aspirates* *X-rays* Other:_____

Any surgery other than spay? ☐ Yes ☐ No If so, describe: _____

Any known adverse reactions to medication or anesthesia? ☐ Yes ☐ No

Current medications and supplements:

Brief Case Summary

Thank you for your referrals

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