Date: ____________ # of pgs in fax: _____

PATIENT REFERRAL FORM

☐ Dallas: adccustomercare@vca.com *(preferred method)*

Tel:972-267-8300 /Fax: 972-267-8301
Critical Care: Dr. Aslanian, Dr. Porterpan
Internal Medicine: Dr. Miller, Dr. Rifkin, Dr. Waters & Dr. Stiller
Internal Medicine/Cardiology: Dr. Nitsche
Oncology: Dr. Custis, Dr. Dawson, Dr. Kovac, Dr. Roof, Dr. Wright

☐ Plano: adcplano@vca.com *(preferred method)*

Tel: 214-667-2244 /Fax: 214-367-3904
Internal Medicine/Cardiology: Dr. Bronstad, & Dr. Rolfe

1 CLIENT / HOSPITAL INFORMATION

Client	Referring Dr.
Home Phone	Hospital
Work/Cell Phone	Phone
Other	Email

2 PATIENT INFORMATION

Name	Sex M MN F FS	Vaccine Status Current Lapsed
Species Canine Feline	Age	HW Preventative Current Lapsed
Breed	Weight lb kg	Handling Precautions?

HISTORY / PE

DIAGNOSTICS

☐ Lab Data
☐ Radiographs
☐ Ultrasound / Echo
(Please send all images)

TENTATIVE DX

COMMENTS

3 REFERRAL REQUEST

☐ Regular Appointment (Next 7-14 days)
☐ Urgent Appointment (Next 3-6 days)
☐ Emergency Appointment (Next 24-48 hours)

Please email all **medical records, lab data, imaging reports** and any other information that will assist in diagnosis to preferred location (see above). Thank you for your referral.