PET SPECIALISTS OF HAWAII

PATIENT REFERRAL FORM

Select service(s) requested:

Date: _____

☐ **Surgery - Dr. Jennifer Song MS, DACVS-SA**

☐ **Imaging Only - Computed Tomography**

☐ **Dentistry - Dr. Marika Constantaras MS, DAVDC**

Referring information:

Primary DVM:		Referring hospital:	
Phone:		Fax:	
Email:		Alternate email:	
Documents sent:	☐ Medical records ☐ Radiographs ☐ Lab work ☐ Dental Radiographs		

Client information:

Client name:		Spouse/Co-owner:	
Address:		City/Zip:	
Home Phone:		Cell Phone:	

Patient information:

Patient name:		Species:	
DOB:		Breed:	
Sex:		Weight (lb or kg):	

☐ **The client will call to schedule appointment**
☐ **Please call client to schedule appointment**

Reason for referral: Case priority: ☐ Urgent
Previous treatments/surgeries:
Current medications:
Additional comments:

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Website: petspecialistsofhawaii.com

Phone/Text:
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