



PET SPECIALISTS OF HAWAII

PATIENT REFERRAL FORM

Date: _____

Select service(s) requested:

Surgery

Dr. Jennifer Song MS, DACVS-SA

Internal Medicine

Dr. Amanda Root DACVIM (SAIM)

Dentistry

Dr. Marika Constantaras MS, DAVDC

Imaging

Computer Tomography

Referring information:

Primary DVM:		Referring hospital:	
Phone:		Fax:	
Email:		Alternate email:	
Documents sent:	<input type="checkbox"/> Medical records	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Lab work <input type="checkbox"/> 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

<i>Reason for referral:</i>	Case priority: <input type="checkbox"/> Urgent
<i>Previous treatments/surgeries:</i>	
<i>Current medications:</i>	
<i>Additional comments:</i>	