

Referral Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_

Sara Mauck Burns, DVM, DACVS-SA Jeff Mauck, DVM Breanna Brash, DVM, MS, DACVO

Board Certified Small Animal Surgeon Email: jwmauck@mw.twcbc.com Board Certified Veterinary Ophthalmologist

Email: [eastpinesburns@gmail.com](mailto:eastpinesburns@gmail.com) Email: [brash.breanna@gmail.com](mailto:brash.breanna@gmail.com)

**Referred By**

Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Doctor E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Owner’s Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Phone Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Work Cell

**Patient’s Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Species: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Altered: Y / N

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient must be current on vaccinations when referred to East Pines Animal Clinic.**

Date of last vaccination\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has pre-anesthetic bloodwork been performed? Y / N

Is the patient currently on medications? Y / N

If yes what medications is the patient on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for Referral**

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**Radiographs**

Have radiographs been taken? Y / N Date radiographs were taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have radiographs been emailed? Y / N Date radiographs were emailed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the radiographs of? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please Fax Form and Patient History to (812)897-4139**