AVIAN AND EXOTIC VETERINARY CARE
PATIENT REFERRAL FORM

Date: _____

Referring Veterinarian Information

Veterinarian Name: _____
Clinic Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone:_____
Email:_____ Fax: _____

Client Information

Owner's Name: _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____
Email: _____

Patient Information

Name of Patient: _____ Birth Date: _____
Species: _____ Breed: _____Color: _____
Sex: _____ Altered: Yes____ No ____ Weight: _____

Chief Concern

_____
_____
_____
_____

History/Physical Findings

_____
_____
_____
_____

avian & exotic
veterinary care

Tentative Diagnosis

_____
_____
_____
_____

Diagnostics & Laboratory Data

Attached _____ With Client _____

_____
_____
_____
_____

Radiographs/Images

Attached _____ With Client _____

_____
_____
_____
_____

Current medication and Treatment

_____
_____
_____
_____

Special Requests/Comments

_____
_____
_____
_____