

ADVANCED VETERINARY CARE SPECIALTY CENTER

21 Hudson Valley Professional Plaza • Newburgh, NY 12550 • Tel: 845.569.3070 • Fax: 845.569.3076

Please print this form, fill it out, and bring it to your first appointment.

Referring Veterinarian: _____ Date: _____

Phone: _____ Fax: _____

Hospital Name: _____

Address: _____ E-mail: _____

Client Name: _____ Patient Name: _____

Age: _____ Species: _____ Breed: _____ Gender: M, MC, F, FS Weight: _____

Referred for Consultation to:

_____ Dr. Rendano, Radiology

_____ Dr. Dillon, Surgical

_____ Dr. St. Vincent, Radiation Therapy

_____ Dr. Hammer, Internal Medicine

Reason for Consultation: _____

Referred for Diagnostic Imaging:

_____ Ultrasound Cavity _____, _____ (please specify cavities)

_____ FNA _____, _____ (please specify location)

_____ Echocardiogram

_____ CT Scan

_____ MRI

Payment option (for ultrasound exams only): _____ Bill Owner _____ Bill Referring Veterinarian

Presenting Complaint and History: *(Please provide a copy of original records when appropriate):*

Physical Examination: _____

Diagnostics: Fill out any pertinent findings *(please provide copies of original reports)*

CBC: _____

Chemistry: _____

U/A: _____

X-Rays: *(Please send with owner when appropriate)* _____

Ultrasound: _____

CAT Scan/MRI: _____

Other: _____

Current Medications: _____