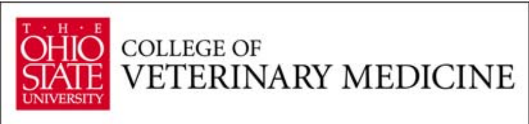
REFERRAL FORM

601 Vernon L. Tharp Street
Columbus Ohio 43210-1089
614/292-3551 fax 614/292-1454



**APPOINTMENTS MUST BE MADE IN ADVANCE
AND EMERGENCIES APPROVED BEFORE DEPARTURE**

SCHEDULED APPOINTMENT: DATE: ____________ TIME: ____________

EMERGENCY APPOINTMENT: ETA: ____________

Service requested:

Emergency/critical care	Internal medicine	Cardiology	Exotics
Dermatology	Oncology	Ophthalmology	Radiation Oncology
General surgery	Orthopedics	Neurology	

Client name: ________________________________ Client phone number: ____________________

Pet name: ________________________ Cat Dog Other Breed: ____________________

DOB: __________ Color: _________ Sex: M F MC FS

Current on vaccines: no yes Date of last rabies vaccination: ______________________

Radiographs: analog digital mailed sent with owner

Diagnostics: not performed faxed sent with owner

CURRENT MEDICAL PROBLEMS/SPECIAL REQUESTS

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PLEASE ATTACH HISTORY AND AVAILABLE CLINICAL PATHOLOGY

APPOINTMENTS: Please have clients call (614)292-3551 for all non-emergency cases. The referring DVM can call the referral coordinator, Stephanie Yochem (614)292-0950 for all emergency/urgent cases.

I have explained to my client that The Ohio State university Veterinary Teaching Hospital charges for services rendered and that if the animal is not admitted, payment in full is required; if admitted, a minimum deposit of $300.00 for estimates up to $1000.00 and $600.00 for estimates of $1000.00 and over is required.

REFERRING VETERINARIAN: ____

CLINIC NAME: ____

PHONE: ____________________ FAX: ______________________ EMAIL: ______________________