Lancaster Veterinary Specialties

Client Name:			
Home Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Pet Name:	Species: Dog ☐ Cat ☐	Breed:	
Color:	Sex: Female ☐ Male ☐	Spayed/Neutered? ☐	DOB or Age:
Referring Veterinarian Veterinary Clinic:		Referring Veterinarian:	
Clinic Address:			
Phone:	Fax Number:	Email:	

Referral Instructions

*Please fax or email this completed form with **2 years** of medical records to info@lancastervs.com.*
Records should include lab work and radiographs. Records must be received prior to the scheduled appointment.

Patient Case History

Department requested: ☐ Cardiology ☐ Internal Medicine ☐ Oncology ☐ Ophthalmology ☐ Surgery

Reason for referral (chief complaint):

Medical History / Clinical signs:

Diagnostics and Procedures:

Current medications / Therapies:

Differential Diagnosis:

1861 Charter Lane, Suite 113, Lancaster, PA 17601 ▪ www.LancasterVS.com
(p) 717-347-0838 ▪ (f) 717-344-5548 ▪ info@LancasterVS.com