



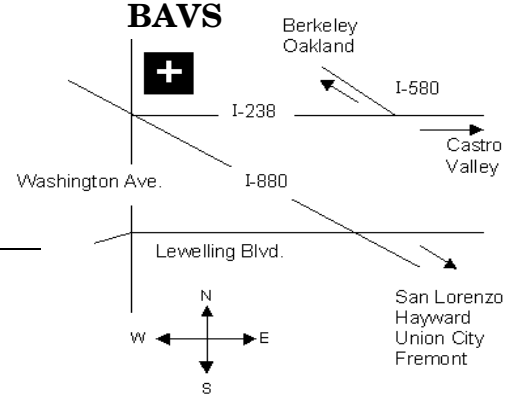
**BAY AREA VETERINARY SPECIALISTS**

14790 Washington Ave.  
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**REFERRAL FORM**

**Fax Form 510.483.7389**

Date: \_\_\_\_\_ Referring DVM: \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Inside Line: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 Pet: \_\_\_\_\_ Client: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_



**Working Diagnosis:** \_\_\_\_\_

**Pertinent historical, laboratory or imaging findings:**

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**Service referred to:**

- |                                                     |                                            |
|-----------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Cardiology                 | <input type="checkbox"/> Neurology         |
| <input type="checkbox"/> Chiropractic               | <input type="checkbox"/> Oncology          |
| <input type="checkbox"/> Dermatology                | <input type="checkbox"/> Medical Oncology  |
| <input type="checkbox"/> Internal Medicine          | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> I-131 Consultation         | <input type="checkbox"/> Radiology         |
| <input type="checkbox"/> Endoscopy                  | <input type="checkbox"/> Ultrasound        |
| <input type="checkbox"/> Urgent care or other _____ | <input type="checkbox"/> CT Scan           |
| <input type="checkbox"/> Emergency / Urgent Care    | <input type="checkbox"/> Surgery           |

**Desired form(s) of contact:**     Telephone Call     Faxed Report     Referral Letter

**BAVS offers on-site CT Scan, Scintigraphy (thyroid, bone, etc. scans) and Ultrasounds**