Bay Area Veterinary Surgery

Surgery Referral Form

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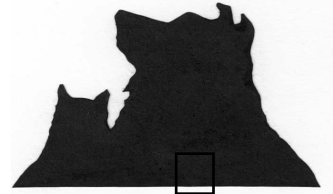

Please take a moment to fill out as much of the following information as possible and fax this form to us anytime prior to the appointment. Please feel free to copy this form for future use. Check here if you would like more client brochures. ☐

Referring Hospital Information

Hospital:______________________________ Referring Doctor: ______________________

Contact number(s): ____

If this is your first referral, please provide the following:

Hospital Address: ____

Fax number: ________________________ Email: ____________________________

Client Information

Name(s):____

Address: ____

City: ______________________________ State:__________ Zip Code: __________

Phone(Home): ______________(Cell) ______________ (Work) ______________

Patient Information, Diagnostics & History

Name:______________________________________ Age:______________________

Reproductive status: Female Spayed Male Neutered

Breed: __________________________ Color: ______________________________

Main reason for referral: ____

Brief patient history or other pertinent information:

Past/current medications (type, route, frequency):

Please attach copies of any current blood work or other diagnostics and send with client any pertinent radiographs.
Also, to avoid unnecessary testing, please let us know if you have any pending diagnostics. Thank you.