3930 North Buffalo St | Orchard Park, NY 14127 | **PH** 716.662.6660 | **FX** 800.284.0306 | **www.opvmc.com**

REFERRAL FORM

Attending Veterinarian:_____**Date:**_____

CLINIC NAME & ADDRESS: _____

Telephone:(____)_____ **E-Mail Address (**Please Print) _____

Client's Name: _____

Address: _____**Zip** _____

Telephone:(_____) _____

Patient: Species: _____ **Sex:** _____ **Age:** _____ **Color:** _____

Breed: _____ **Pet's Name:** _____

History: (Please include pertinent laboratory findings as well as treatment dates and dosages.)

Tentative Diagnosis: _____

Special Requests/Reason for Referral: _____