



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: _____

***please note this form can be found on our website. We also encourage you to submit referrals via our online portal:

<https://www.opvmc.com/rvetlink/>