WOODCROFT REFERRALS CASE SUBMISSION FORM

WOODCROFT
Veterinary Hospital

Please send a copy of the clinical history and any relevant laboratory results, X-rays, ECG's, etc in time for the appointment.

In emergency cases, telephone 0161 486 2333

Xrays can be emailed to hospital@woodcroftvets.com

Discipline

MRI/CT		Dermatology		Internal Medicine		Behaviour		Cardio-respiratory	
Soft Tissue		Hydro/Physio		Orthopaedics		Ophthalmology		Dental/Maxillofacial	

Vets Opinion

Emergency (Within 24 hrs)		**Urgent** (Within 3 days)		**Non Urgent** (Next available appointment)	

Vets Comments	

Referring Practice

Practice Name:	
Telephone:	Fax:
E-Mail:	
Referring Veterinary Surgeon:	

Client Details

Mr/Mrs/Other	First Name:	Surname:
Address:		
Post Code:		
Tel Home:	Tel Work:	Mobile:

Pet Details

Name:	Age:	Dog/Cat	Sex: M/F	Entire/Neutered
Breed:				
Current Medications:				
Insured Y/N Insurance Company:				
Previous claim for same condition: Y/N Claim wording:				

Information

Condition being referred:
Brief History/Referral Request:
Recent Medications:
Is the client aware of likeley referral costs?: Y/N How much has been estimated?: