

Please send us the patients current medical records, lab work, or any other related information along with this referral form prior to their appointment, Thank you.

****Please direct your Client to call STVO directly to schedule their appointment.****

Phone : (210) 962-5388 **Fax :** (210)998-6830 **Email :** reception.stvopets@gmail.com

Date: _____

Status of Referral Appointment: **URGENT**

***If you feel this patient needs to be seen as an emergency, please call and speak to an STVO doctor or an administrative staff member ASAP, so that we can do our best to get them in quickly. If you mark this as an Urgent referral we will do our best to get the patient seen in the next 48 hours.*

DVM REFERRAL CONTACT INFORMATION:

Clinic Name: _____

Referring Doctor Name: _____

Phone: _____ Fax: _____

Email(s): _____

CLIENT CONTACT INFORMATION:

Owner Name: _____

Cell Phone: _____ Home Phone: _____

Mailing Address: _____

Email(s): _____

Does this client require a Spanish Speaker? Yes No

PET REFERRAL INFORMATION:

Pet Name: _____ Dog Cat Other: _____

Sex: Male Neutered or Female Spayed Weight: _____

Breed: _____ Age/DOB: _____

Is the Patient Aggressive? No Yes, explain: _____

Clinical Questions:

Is the patient Diabetic? Yes No

Was blood work taken? Yes No If yes, When? _____ *PLEASE SEND COPY*

Fluorescein Stain OD: _____ OS: _____ Date: _____

Tonometry OD: _____ OS: _____ Date: _____

Schirmer Tear Test OD: _____ OS: _____ Date: _____

Tentative Diagnosis:

Brief History & Problem Report:

Other Medical conditions or concerns:

List of Current Medications (including medications for other comorbidities):

Thank you for this information. Please do not hesitate to contact STVO for consultations or questions anytime.

**South Texas Veterinary Ophthalmology
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www.stvopets.com