

Mark Davis, DVM, DACVS, CCRP
Board Certified Surgeon

11308 92ND St SE
Snohomish, WA 98290
Tel: 360-282-4019
Fax: 360-282-4449
Email: surgery@pilchuckvet.net



SURGERY REFERRAL FORM

To facilitate a smooth transfer, contact us prior to sending client.

Service Requested: Surgery

Referred by: _____

Referring Hospital: _____

Phone: _____ Fax: _____

Case Status: Emergency (within 24hrs) Priority (within 48hrs) Routine (next available)

If through Emergency department would you like the case transferred back in the morning? _____

Name of client: _____

Phone: #1 _____ #2 _____

Patient's Name: _____

Species: Canine Feline Other: _____ Breed: _____

Sex: F FS M CM Unknown Age: _____

Tentative Diagnosis/ Chief Complaint:

History/ Physical Findings:

Lab Results:

Current Treatments/ Medications:

Special Requests/ Comments:

Send the images with the client and fax all other history, lab work, treatments, etc. THANK YOU!