THE VETERINARY HOSPITAL GROUP REFERRALS CASE SUBMISSION FORM

Please send a copy of the clinical history and any relevant laboratory results, Xrays, ECGs, etc in time for the appointment.

Email: office@plymouthvets.co.uk or Fax back to: 01752 773305

If this case is URGENT please tick here: ☐

In emergency cases, telephone: 01752 702646

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:	
E-mail:		Mobile:	

Pet details

Name:	Age:	Dog/Cat	Sex **M/F**	entire/neutered
Breed:				
Current medications:				
Insured **Y/N** Insurance Company:				
Previous claims for same condition **Y/N**				

Information

Condition being referred:	For the attention of:	MRCVS
Brief history/referral request:		
Is the client aware of likely referral costs? **Y/N** How much has been estimated? **£**		

www.plymouthvets.co.uk