



Animal Health Trust

## Animal Health Trust

*Small Animal Referral Centre*

Direct telephone: +44(0) 1638 552700

**ROUTINE REFERRAL FORM - Fax completed form to 01638 555 600**

**or Email [smallanimal.centre@aht.org.uk](mailto:smallanimal.centre@aht.org.uk)**

**If this referral is an emergency, please call 01638 6552700**

ROUTINE REFERRAL

ADVICE REQUEST

### REFERRAL SERVICES

ANAESTHESIA

DERMATOLOGY

DIAGNOSTIC IMAGING

HYDROTHERAPY

INTERNAL MEDICINE

NEUROLOGY & NEUROSURGERY

ONCOLOGY

OPHTHALMOLOGY

PHYSIOTHERAPY

SOFT TISSUE SURGERY

SERVICE REFERRED TO: \_\_\_\_\_ DATE: \_\_\_\_\_

SPECIFIC REASON(S) FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### CLIENT INFORMATION:

CLIENT: \_\_\_\_\_ ANIMAL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

DOB: \_\_\_\_\_ M  F  N  DOG  CAT  BREED: \_\_\_\_\_ Colour \_\_\_\_\_

IS THE ANIMAL INSURED? Y  N  IF YES, WHO WITH: \_\_\_\_\_

Please provide a brief summary of the case history and any other pertinent comments

Please attach to this form a full history and all relevant laboratory results

\*Radiographs will be returned by mail unless otherwise specified by you. Please label your radiographs with your hospital name and address as well as patient name and information\*

#### REFERRING VETERINARIAN INFORMATION:

PLEASE CONTACT ME BY: EMAIL  PHONE  FAX

REFERRING VETERINARIAN: \_\_\_\_\_

HOSPITAL/PRACTICE: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Vet's Signature: \_\_\_\_\_

Are you happy for us to contact your client directly to arrange a mutually convenient appointment?

Yes  No