Doctor & Hospital Name:_____
Phone: _____Fax:
Date: _____
6651-F Backlick Road, Springfield VA 22150 (703-451-8900) (Fax 703-451-3343) www.vetreferralcenter.com rvrc@erols.com

Please Specify The Veterinarian You Are Referring To:

Client Name: Patient Name:

Age:_____ Species: Breed: Sex: Weight:

Presenting Complaint:

History/Physical Examination: (please provide a copy of original records)

Presumptive Diagnosis:

Please provide copies of all the pertinent labs (CBC, diagnostic panel, UA, C&S), imaging (radiographs, MRI, CI) and other diagnostics Current Medications:

Should we contact you at home if there are significant changes? Phone number:

If this is an emergency case, would you like this case returned the following day? Yes__ No__

Cardiology

Bonnie K. Lefbom, DVM, DACVIM
Jennifer A. Sidley, DVM, DACVIM

Dermatology

Bruce L. Hansen, DVM, DACVD

Emergency/Critical Care

Rand S. Wachsstock, DVM
Kimberly Bridges, DVM
Randy Derbin, VMD
Rachel Kesting, DVM
Megan Kees, DVM
Montine Mansell, DVM

Internal Medicine

Clayton G. Kilrain, DVM, ACVIM

Neurology

Jessica Barker, DVM, DACVIM
William Bush, VMD, DACVIM

Radiation Oncology

Ira Gordon, DVM, DACVR

Medical Oncology

Chand Khanna, DVM, PhD, DACVIM
Bridget Stewart, VMD

Radiology

David S. Herring, DVM, DACVR

Rehabilitative Therapy

Morgan Francis, MS, DPT, CCRP

Surgery & Surgical Oncology

Greg Griffin, MVB, MRCVS, DACVS, DECVS
Rochelle B. Anderson, DVM, DACVS