GLENWAY ANIMAL HOSPITAL
SURGERY REFERRAL FORM

AAHA ACCREDITED
The Standard of Veterinary Excellence

Client Information	Referring Veterinarian Information
Owner's Name:	Doctor's Name:
Address:	Clinic Name:
	Phone:
Phone:	Fax:
Email:	Email:
Is there an additional owner? ☐ Yes ☐ No	Contact Preference:
Name:	☐ Phone ☐ Fax ☐ Email
Phone:	

Patient Information		
Name:	Species:	Breed:
Age:	Weight:	☐ M ☐ MN ☐F ☐FS
Presenting Complaint/Reason for Surgical Referral:		
Past Pertinent History/Concurrent Illness:		
Current Medications:		
Known Anesthetic/Medication Sensitivities:		
Diagnostics Completed (Please include results as attachment or via email): ☐ Chemistry Profile ☐ Radiographs ☐ Ultrasound ☐ Urinalysis ☐ CBC ☐ FNA ☐ Biopsy ☐ MRI ☐ Other:		

Please fax or email Referral Form and Medical Records (send radiographs via email):
(513) 662-1010 or surgery@glenwayanimalhospital.com