A.V.U.E

Paul Berdoulay DVM, DACVIM (SAIM)

Affordable Veterinary Ultrasound, Endoscopy, and Internal Medicine

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Patient Referral Form

Primary Care Hospital Information

Veterinarian: _____ Hospital: _____

☐ Phone:_____ ☐ Fax:_____

☐ E-mail:_____ ☐ Cell phone:_____

Please check box if there is a preferred method of contact.

Client and Patient Information *(Please ask client to call to schedule a consultation.)*

Client: _____ Address: _____

Phone: _____ E-mail:_____

Patient Name: _____ ☐ Canine ☐ Feline

☐ F ☐ F^{spayed} ☐ M ☐ M^{castrated} DOB/Age: _____ Breed: _____ Color: _____

Patient Medical Synopsis

Diagnosis and/or Reason for Referral:

_____

Pertinent Medical History: _____

_____

_____

_____

_____

_____

_____

_____

Current Medications:

_____

_____

_____

Please attach copies of all prior diagnostics and SOAPS. Email imaging to avueexpert@gmail.com.

THANK YOU for choosing us to collaborate on the care of your patient.

ACVIM Diplomate