



# REFERRAL FORM

CARE SURGERY CENTER

☎ 623.328.9007

6677 W. Thunderbird Rd / Building L188  
Glendale, AZ 85306

## Referring Veterinarian Information

Referring Veterinarian's Name \_\_\_\_\_ Referral Date \_\_\_\_\_

Hospital Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

## Referred Client and Patient Information

Client Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Client Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient Name \_\_\_\_\_  Male  Female Age \_\_\_\_\_ Altered?  Yes  No

Species \_\_\_\_\_ Breed \_\_\_\_\_ Color \_\_\_\_\_

## Service Requested

- Surgery Consult
- Minimally Invasive Surgery
- Orthopedics
- Cruciate Ligament (TPLO)
- Fractures
- Soft Tissue Surgery
- Abdominal Surgery
- Thoracic Surgery
- Oncological Surgery (Cancer)
- Emergency Surgery
- Spinal Surgery

## Reason for Referral / Exam Findings

## Sending Records By:

- Fax **623.440.5709**
- Email **referrals@caesurgerycenter.com**
- With Client

*Please include a copy of medical records, lab work and radiographs (if available) with referral.*

