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ANIMAL EYE CARE LLC

COMPREHENSIVE CONSULTATION ◆ SURGERY OF THE EYE
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Please fax this completed form to us AND have the owner call us for an appointment. Please feel free to call us if you have any questions or concerns. It is our pleasure to assist you in the care of your patient.

PATIENT REFERRAL INFORMATION SHEET

VETERINARIAN INFORMATION:

Date:_____

Veterinarian:_____ Hospital: _____

Phone: (_____) _____ Fax: (_____) _____

_____
STREET ADDRESS CITY STATE/PROVINCE ZIP CODE/POSTAL CODE

PATIENT INFORMATION:

Vaccination Status:_____

Client's Name:_____

Phone: H (_____) _____ W (_____) _____

C (_____) _____

Patient's Name:_____

Age: _____ D.O.B._____

Breed:_____

Sex: M Mn F Fn

Patient's Temperament: good nervous go slow may bite will bite muzzle

Best method of restraint:_____

CLINICAL SIGNS AND HISTORY:

EYE(S) INVOLVED: RIGHT (OD) BOTH (OU) LEFT (OS)

Present Ocular Conditions and Clinical Signs: _____

_____

_____

_____

Treatment and Response (include frequency and mg/concentration of drugs used):_____

_____

_____

Tentative Diagnosis, Comments and Concerns:_____

_____

_____

Previous Ocular Surgeries: _____

Current Medications, Adverse Reactions/Allergies, and other Diseases present:_____

_____

_____

_____

_____

Lab History *(please fax most recent labwork and medical record)*: CBC Date:_____ Serum Chemistry Date:_____

Other Lab: _____ FELV ☐ FIV ☐ Date(s):_____

Other Tests: *(any test results pending? PLEASE FAX THEM WHEN THEY ARE RECEIVED)* _____

_____

IF DOG IS DIABETIC: Is Diabetes Controlled? _____ *When first diagnosed?*_____

Assessment of Anesthetic Risk: [LOW MED HIGH] ***or*** [I II III IV V VI VII]