Referral form for Internal Medicine – Dr. Koch

REFERRING DR:	HOSPITAL:	HOSP. PHONE:

Owner's Name: Phone #

Address:

Patient's Name: Breed: Color:

Date of Birth: Sex: Species:

RABIES given: **1 or 3yr** **DHPP/FVRCP given:** **1 or 3yr**

Please attach any current and past blood/labwork:

Date Referred: Duration of problem:

Reason for Referral:

Ultrasound Region: Thyroid/Parathyroid: ☐ Non-cardiac thoracic: ☐ Abdomen: ☐

Brief medical history (anything relevant in the past along with current issues, include any treatments, dates, etc)

Major exam findings or clinical concerns:

Working DDX:

Current medications & dosages:

Referral update letters to be e-mailed to: ☐ _____ or faxed (#) ☐ _____

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