



187 Sheffield Road, Killamarsh, S21 1DY tel: **01142 470828** fax: **01142 514725**

[www.arkvetsheffield.co.uk](http://www.arkvetsheffield.co.uk)

## EXOTICS REFERRAL REQUEST FORM

fax: **0114 2514 725**

Please note this form is for Veterinary Referral only

Date: \_\_\_\_\_ Referring Practice: \_\_\_\_\_

Referring Veterinary Surgeon: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

If we need to contact you regarding your referral,  
how would you prefer to be contacted?  
(please circle)

Telephone

Email

Fax

### Your Client

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Email: \_\_\_\_\_

Pets Name: \_\_\_\_\_ Age: \_\_\_\_\_

Species/Breed: \_\_\_\_\_ Sex/Neutered: \_\_\_\_\_

Brief History / Clinical Signs: \_\_\_\_\_

Recent Medication: \_\_\_\_\_

Investigations to date: \_\_\_\_\_

Suspected Diagnosis: \_\_\_\_\_

Is the Appointment? (please circle):

1. Emergency

2. urgent – next day

3. not urgent – next available appointment

Are you happy for us to call your client to arrange the appointment? (please circle) YES / NO