Veterinary Oncology Services

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DACVIM (Oncology), MRCVS

PATIENT REFERRAL FORM

Please provide the following information

Referring Doctor	Hospital Number
Referring Hospital	Hospital Email
Client Name	Patient Name
Client Phone/Email	Species / Breed / Sex / Age

How would you prefer to be contacted about this case?

❒ Phone ❒ Email

Presenting Diagnosis: _____

Case History: Please include duration of illness, clinical signs, and treatments—
Please email any diagnostic reports and imaging to info@petcancerinformation.com:

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Specific comments, concerns of referring / primary care veterinarian:

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For an appointment or to discuss a case, please call 845.205.2768.
Thank you in advance for the above information and for your trust in our care.

Tel 845.205.2768 ● Fax 845.205.2938
● www.petcancerinformation.com
● info@petcancerinformation.com