For UCDVH Use Only	
*Name:*_____	
SAM: _____ *S AS:* _____ *Other:*_____	
*Apt Day:*_____ *Date:*_____	
History: Yes / No	*Results: Yes / No*
Images: Yes / No	*Videos: Yes / No*
Forwarded: Yes / No	*Urgent: Yes / No*

UCDVH REFERRAL REQUEST FORM

Date:

*PLEASE NOTE: Please complete this form and EMAIL to **vethub@ucd.ie** and send (together) with the clinical history, diagnostic reports and images if available.*

EMERGENCY? *Yes -* ☐ *No -* ☐ *(If referral is urgent please call 01 7166200 to bring this to our attention.)*

Referral Sought: *Medical:* ☐ *Surgical:* *2nd Opinion images:* ☐

Pain Clinic: ☐

☐ -*Orthopaedic*
☐ - *Soft Tissue*
☐ - *Neurosurgical*

Practice Name and Address:

Veterinarian's Name:

Tel: Mobile: Email:

Client's Name:

Address:

Animal's Name:			Species:	Breed:	
Sex:	Entire:	Age:	Colour:	Weight:	Insured?

Reason for Referral: *(And attach clinical history with laboratory reports, imaging, photographs and videos if any)*

Treatment/Current Medication:

Handling precautions / Known Adverse Drug Reactions:

Additional Comments:

Extending box?

Attachments: *Clinical History*: ☐ *Laboratory Report/s:* ☐ *Imaging:* ☐ *Photos:* ☐ *Video/s:* ☐

Date Received by UCDVH: _____

Date Received by UCDVH: _____