Pittsburgh Veterinary Dermatology Referral Form

801 Commonwealth Dr, Warrendale, PA 15086
Phone: 412-274-1400 Fax: 724-426-7717

Date:____________

REFERRING VETERINARIAN:____
PRACTICE:____
ADDRESS:____
TELEPHONE:_______________________ FAX:_____________________________

OWNER NAME: _____________________ PATIENT NAME:____________________
Address 1: ______________________ Species:_________________________
Address 2:_______________________ Breed:___________________________
Home Phone: _____________________ Sex:__________ Neutered? **Y N**
Wk/C Phone: _____________________ Age:__________ Weight:________Kg
Email: __________________________ Vaccine Status:__________________

REASON FOR REFERRAL:____

PERTINENT HISTORY:____
____
____
____
____
____

LAB RESULTS (fax blood work, cytology, & biopsy reports; send x-rays with owner)
____
____
____
____

MEDICATIONS (DOSAGE / DURATION / RESPONSE):
____
____
____

REMARKS OR REQUESTS:____

Please discuss the cost of specialty care with your client prior to referral.
A tentative estimate will be provided when they call to make an appointment.

Office Use: Estimate: ______________ Priority: __________________ Initials: ________