

Torrington Orthopaedics Referral Form

Fax to 01484 404771

This form is for veterinary use only

Case Type: Urgent Non Urgent

Referring Vet Details

Referring Surgeon Name:

Referring Practice Name:

Practice Address:

Telephone: Fax:

E Mail:

Client Details Have we seen this client before? Yes No

Client Name:

Client Address:

Telephone: E Mail:

Patient Details Have we seen this patient before? Yes No

Patient Name: Species: Canine Feline Other

Breed: Sex: M M(n) F F(n)

Date of Birth: DD/MM/YYYY Or Age: Year(s) Months Weight: Kg

Clinical Problem Details

Nature of Problem: Orthopaedic: Spinal: Unknown:

Affected Limb(s): Left Fore: Right Fore: Left Hind: Right Hind

Tentative Diagnosis:

Current Medication(s):

Have you spoken to one of our surgeons?: Yes: Andy Turlough Ciara Andrea

Diagnostic Tests Performed:

Radiography: Have we reported on these? Yes No

Aspirates: (Please send Lab report.)

Haematology and Biochemistry: (Please send Lab Report)

Histopathology: (Please send Lab Report)

Other Relevant Information: