TRINITY
INTERNAL MEDICINE
REFERRAL CENTER

Referral Data Form

3100 N. Perkins Road
www.trinityveterinaryhospital.com

Phone Number:
405-633-6360

Fax Number:
405-533-0002

TIMRC Medical Information Email:
internalmedicine@trinityveterinaryhospital.com

PLEASE COMPLETE ENTIRELY

- Please complete this form with all requested information and email or fax to our referralcoordinator along with all bloodwork, radiographs and any other pertinent diagnostics
- Once all requested information is received, the client will be called by our referralcoordinator, Jackie Zehr, to schedule an appointment
- If possible, animal should be fasted for 8-12 hours prior to appointment

Referral Date: _____

Referring Veterinarian _____ **Clinic/Hospital:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Alternate Phone _____ **Preferred Method of Contact** **email** ☐ **fax** ☐ **phone** ☐

Owner's Name: _____ **Spouse/Co-Owner** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Work Phone:** _____ **Email:** _____

Animal Name: _____ **Species:** _____ **Sex:** _____

Date of Birth: _____ **Color:** _____ **Breed:** _____

Reason for Visit:

Medical History: Continue of next page if needed

Medication 1		**Dosage:**	**Frequency:**
Medication 2		**Dosage:**	**Frequency:**
Medication 3		**Dosage:**	**Frequency:**
Medication 4		**Dosage:**	**Frequency:**
Medication 5		**Dosage:**	**Frequency:**

Diagnostics Performed

☐ **CBC** ☐ **Chemisty Profile** ☐ **Thyroid** ☐ **Urinalysis** ☐ **Radiographs** ☐ **Abdominal Ultrasound** ☐ **Thoracic Ultrasound** ☐ **GI Panel**

Other:

Please sign to confirm information is accurate and complete.
This signature also affirms you have discussed with your client that we are an outpatient facility and not equipped for critical patients.

Type your Name to Sign

Additional History

Other Information