

TVSS REFERRAL FORM



REFERRING CLINIC	
Practice Name	
Referring Veterinarian	
Phone Number	
Email	

CLIENT INFORMATION	
First Name	
Last Name	
Mobile	

PATIENT INFORMATION	
Pets Name	
Owner's Last Name	
Species	
Breed	
Age In Years	
Sex	
Weight in kg	
Urgency (critical, urgent, non-urgent)	

Send to:
tasvetsurgicalspecialists@gmail.com

**Tasmanian Veterinary
Surgical Specialists**



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Reason for Referral	
History	Please attach documents
History Summary	
Blood and Lab Results	Please attach documents
Blood and Lab Results Summary	
Imaging	Please attach documents
Imaging Summary	

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