



### REFERRING PRACTICE DETAILS

Name: ..... Tel: .....

Branch: .....

Address: ..... Fax: .....

.....

..... Email: .....

### REFERRING VETERINARY SURGEON

..... Qualifications: .....

I **do / do not** require a referral consult in addition to the MRI scan (please delete as appropriate).

This is a referral for: MRI / Orthopaedics / Soft Tissue Surgery / Spinal Disease (please delete as appropriate)

### OWNERS DETAILS

Title: ..... Initial: ..... Surname: .....

Address: ..... Home tel: .....

..... Work tel: .....

..... Mob tel: .....

### PATIENT DETAILS

Name: ..... DOB/Age: ..... Sex: .....

Species: ..... Breed: .....

Insured: YES / NO Insurance Company: .....

### GENERAL PATIENT HISTORY

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### CLINICAL SYMPTOMS & FINDINGS

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### CURRENT MEDICATION

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The case notes will be:  Faxed  Posted  Owner to bring  Not applicable

Please post or fax with this form to:  
 Wear Referrals 5-11 Tenters Street Bishop Auckland Co. Durham DL14 7AD  
 Tel: 01388 602707 Fax: 01388 605660  
 Email: info@wear-referrals.co.uk Web: www.wear-referrals.co.uk