ROADRUNNER VETERINARY
EMERGENCY & SPECIALTY HOSPITAL

Surgical Referral Form

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Email: surgery@roadrunnerVetER.com
P: 505-384-6420
F: 505-384-6419

Date: _____

Referral Urgency:

- o **Emergency: Please contact the hospital at 505-384-6420 *Surgical Coordinator: Tues.-Fri. 8am-5pm***
- o **This Week** ***Client Liaison: 7 days a week***
- o **Next Available**

Referring Veterinarian Information

Referring Hospital: _____
Referring DVM: _____
Phone: _____
Email: _____
Fax: _____

Client Information

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Email: _____

Preferred contact method: o Email o Fax

Patient Information

Pet's Name: _____ o Canine o Feline

o Male o Female o Spayed/Neutered

Breed: _____ Color: _____

DOB: _____ Weight: _____ kg

Medical Records	o Emailed to surgery@roadrunnerVetER.com	o None
Radiographs	o Emailed to surgery@roadrunnerVetER.com	o None
Lab Results	o Emailed to surgery@roadrunnerVetER.com	o None

Reason for Referral:

_____

_____

Relevant Medical History/Diagnostics:

_____

_____

Current Medications/Supplements:

_____

_____

Additional Information:

_____

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