



Referral Paperwork

Specialty Referral:		Internal Med	Surgery	Acupuncture	Chiropractic	TCVM	
Is this referral urgent? Yes or No				Specific Doctor Request:			
Reason for Referral/Primary Complaint:							
Expectations for this Case:							
Additional Comments/Pertinent History/Vaccine History/Tentative Diagnosis:							
Hospital Name:				Phone Number:			
Veterinarian's Name:				Fax Number:			
Submitted By:				E-mail Address:			
Client's First Name:				Client's Last Name:			
Address:				City:	State:	Zip:	
Primary Phone Number:				Secondary Phone Number:			
E-mail Address:							
Patient's Name:				Species:		Sex:	
Breed:				DOB/Age:		Weight:	
Rabies Vaccine Type:				Rabies Expiration Date:			
Is patient suspected to be infectious?				Is patient fractious or painful?			

Please have the client bring hard copies of all records, email to us at info@allure.pet, or fax to 210-519-2989