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Veterinarian Referral Request

Jeannette M. Kelly, DVM, Diplomate ACVIM, Oncology

Referring Doctor _____ Date _____
Referring Hospital _____
Address _____ Zip _____
Phone _____ Fax _____ Email _____

Name of Client _____
Best Contact Number _____ Cell _____

Patient's Name _____ Age or birth date _____
Species _____ Breed _____ Weight _____
Sex () F () SF () M () NM

Tentative Diagnosis/Chief Complaint _____

Have you performed:

Histopathology/Cytology

CBC

Full Blood Chemistry

Urinalysis

Radiographs

If yes, are they digital?

Did you submit for radiology review? And where? _____

Please attach results from any of the above tests you have performed.

Other health problems, allergies, drug/diet restrictions and
precautions _____

