



Veterinary Cancer Care, P.C.
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Veterinarian Referral Request

Jeannette Kelly, DVM, Diplomate, ACVIM (Oncology)

Referring Doctor _____ Date _____

Referring Hospital _____

Address _____ Zip _____

Phone _____ Fax _____ Email _____

Name of Client _____

Address of Client _____

Best contact Number _____ Work _____ Cell _____

Patient's Name _____ Age _____ Birth date _____

Species _____ Breed _____

Weight _____

Sex () F () SF () M () NM

Tentative Diagnosis/Chief Complaint _____

History/Physical Findings _____

Laboratory, Biopsy, Cytology Findings (please fax copies) _____

Radiograph and Ultrasound Findings (please send films with client, they will be returned) _____

Treatments (please include all current medications and dosages) _____

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

Please have your client call to schedule an appointment