Plateau Animal Hospital: Ophthalmology Referral Form

Fees charged reflect the quality and value of our advanced and specialized medical and surgical services. They also reflect the degree of expertise required to diagnose and treat your pet, as well as the cost of the diagnostic, therapeutic and surgical equipment utilized. Written estimates are provided for patients for which surgery and/or advanced diagnostic procedures under sedation or general anesthesia are recommended. Fees are payable in full when services are provided, in the form of a major credit card (Visa, MasterCard, Discover, American Express, Care Credit), a debit card, check or cash.

DATE: _____ **PET'S NAME:** _____

OWNER'S NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: (home) _____ **(work)** _____ **(mobile)** _____

EMAIL: _____

PREFERRED METHOD FOR CONTACT: _____

REFERRING CLINIC & VET: _____

REFERRING CLINIC EMAIL: _____

FAX NO.: _____ **PHONE:** _____

ABOUT YOUR PET:

BREED: _____ **COLOR:** _____ **AGE:** _____ **SEX:**_____

SPAYED/NEUTERED? _____ WEIGHT: _____ DIABETIC: _____ IMMUNIZATIONS CURRENT? _____

PLEASE LET US KNOW THE CHANGES YOU'VE OBSERVED REGARDING YOUR PET'S EYES:

- **WHICH EYE(S) HAVE YOU NOTICED HAVING PROBLEMS? _____**
- **WHAT CHANGES DID YOU OBSERVE? _____**
- **HOW LONG HAVE THE CHANGES BEEN PRESENT? _____**
- **HAS YOUR PET RECEIVED THERAPY/MEDICATIONS FOR THIS PROBLEM? IF SO, PLEASE LIST THEM: _____**
- **DID ANY OF THESE TREATMENTS HELP? IF SO, PLEASE LIST THEM: _____**
- **OTHER HEALTH CONDITIONS/MEDICATIONS? _____**