### MVSS Surgical Referral Form

1635 Reeves Rd  
Bozeman, Montana 59718  
Phone: 406-587-4458  
Fax: 406-994-0338

<table>
<thead>
<tr>
<th>Please Circle One:</th>
<th>Owner will contact us</th>
<th>Please Contact Owner</th>
</tr>
</thead>
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**Referred by Dr.**  
**Referring Hospital:**  
**Address:**  
**Phone:** (   )  
**Fax:** (   )

**Name of Client:**  
**Address of Client:**  
**Home Phone:** (   )  
**Cell Phone:** (   )  
**E-mail Address:**

**Patient's Name:**  
**Species:**  
**Breed:**  
**DOB:**  
**Sex:**  (circle one)  
F  SF  M  CM  Unknown

**Tentative Diagnosis/Chief Complaint:**

**History/Physical Findings:**

**Laboratory Data, CBC, Full Chemistry, and Urine Specific Gravity** are required if surgery is necessary (Please attach copies of results):

**Treatments** (Include all medications and dosages):

**Were radiographs taken?:**  
**What films/views were sent?:**

**Special Request/Comments:**

**Did you send pertinent medical history with referral form?:**