

Clinic Chop: _

Signature of Doctor: _

◆ Shop No. 12-17, G/F Harbour Crystal Center, 100 Granville Road, Tsim Sha Tsui East, Kowloon

Case Referral Form

	Booking Date :	Time :
To be completed by rDVM only		
Patient Information :		
Patient Name :	Owner Information :	
Date of Birth : Age:	O Mr. O Mrs. O Ms.	
Sex : O Male O Female	Name :	
Breed :	Phone :	
Species: O Canine O Feline	Neutered: O Yes O No	0
Referral to Neurology / Cardiology / Surgery / Internal Medicine or	others, please specify :	
□ Neurology		
☐ Cardiology		
□ Surgery		
☐ Internal Medicine		
□ Others		
Reason for referral :		
		l :
Clinical information (patient history / current treatments / specific a	arrangements required / any medica	i image) :
Comment on a direction of		
Current medication :		
Allergy history of : ☐ Contrast medium		
☐ Other allergies :		
DVM information		
Veterinarian Name :	Email :	
Veterinary Clinic :	Address :	
Clinic Phone :		