



New Patient Referral Form

North Hills
807 Camp Horne Rd
Pittsburgh, PA 15237

South Hills
1535 Washington Rd
Washington, PA 15301

P:412-366-3400
F:412-366-3489

Referring Veterinarian: _____

Practice: _____

Address: _____

Phone: _____ Fax: _____

***Please provide your **REFERRAL CLINIC EMAIL** on the line below for communications:

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Patient Name: _____

Species: _____ Breed: _____

Sex: _____ Age/DOB: _____ Weight: _____ lbs Vaccine Status up to date? _____

Reason for Referral: _____

This case is: URGENT _____ NOT URGENT _____

Pertinent History: _____

Diagnostic results: (prior to your patient's appointment, please fax or email blood work, radiographs (jpeg format), and medical records) to: cardiocsr@pittvetcardiology.com

Medications (Dosage / Duration / Response): _____

Remarks or Requests: _____

*Please discuss the cost of specialty care with your client prior to referral.

A tentative estimate will be provided when the appointment is scheduled.

Office use: Estimate: _____ Priority: _____ Initials: _____