

Buffalo Veterinary Group

Orthopedic Surgery - DVM Referral Form



- Please complete the following information.
- Email all medical records and diagnostic results to ortho@buffaloveterinarygroup.com.
- We will contact the owner to schedule a consultation.

Referring Veterinarian:

Hospital Name:

Hospital Address:

Hospital Email:

Hospital Phone:

Client Name:

Client Address:

Client Email:

Client Phone:

Patient Name: _____ **Breed:** _____

DOB: _____ Color: _____ Sex: M F Spayed/Neutered

Weight: _____ Current on Vaccines: Yes No

Master Problems:

Current Medications:

Tentative Diagnosis:

Patient History:

Diagnostics and Date Performed:

CT: Yes / No / Unsure

Specific requests:
