



Cascade Veterinary Specialists
Referral Data Form

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Phone: 425-391-5015 Fax: 425-391-4916

If possible, the patient should be presented after an 8 to 12 hour fast.

Date of referral: _____

Referring Veterinarian: _____ Clinic/Hospital Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Email: _____

Owner's Name: _____ Spouse/Co-owner (s): _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Patient's Name: _____ Species _____ Sex: Male Neutered

Age: _____ Color: _____ Breed: _____ Female Spayed

Tentative Diagnosis / Primary Complaint:

Pertinent Medical History: _____

Medication History (dates & dosages): _____

Clinical Pathology History **(Please send copies and include lab normals):** _____

Other Testing (ECG, Radiographs, Ultrasounds, CT/MRI):

If radiographs were taken, please send them with the client or via courier if time allows.

Signature of Referring Veterinarian

