

CENTRAL HOSPITAL FOR VETERINARY MEDICINE
Oncology Service
Patient Referral Form

Please return to Dr. Olmsted at Central Hospital for Veterinary Medicine by e-mail or fax. Please send medical records and test results prior to the date of appointment. Include any hard film radiographs labeled with clinic name and return address. Please email any digital radiographs.

Clients may call seven days a week to schedule a consult. Dr. Olmsted is available for appointments or to discuss a potential referral Tuesday to Friday.

Gina Olmsted, DVM (Practice Limited to Oncology)
Oncology Service
Central Hospital for Veterinary Medicine, Inc.
Referral and Emergency Center
4 Devine Street
North Haven, CT 06473
Phone: (203) 865-0878
Fax: (203) 867-5195
Email: oncology@centralpetvet.com

Date: _____

Referring Veterinarian Information:

Doctor's Name: _____ Hospital Name: _____
Address: _____ City: _____ State _____ Zip _____
Phone: _____ Fax: _____
E-Mail: _____

How would you prefer to be contacted about this case?

Phone Fax E-mail

Client Information:

Name: _____
Phone: _____ E-mail _____

Patient Information:

Name _____ Species _____ Breed _____
Sex _____ Neutered: Yes No Age _____

Reason for Referral:

Medical History:

Past relevant history:

Medical treatments and current medications and supplements:

Diagnostics already performed/pending:

Please list tests performed and any radiographs that were emailed:

Pending tests:

Name of lab for pending tests:

How will medical records be sent?

Fax Email (preferred)

Thank you for your referral!
We look forward to being part of your patient's medical team.