

Internal Medicine Consult Request

Date:

Patient Information	
Patient ID/Number: <small>(if seen at VMTH before)</small>	
Name:	
Age:	<input type="checkbox"/> yr <input type="checkbox"/> Estimated <input type="checkbox"/> mo age?
Sex:	<input type="checkbox"/> FS <input type="checkbox"/> MN <input type="checkbox"/> FI <input type="checkbox"/> MI
Breed:	
Species	<input type="checkbox"/> Canine <input type="checkbox"/> Feline

Owner Information
Name:
Last Name:
Phone#:
Alt.Phone#:

Veterinarian Requesting Consult Information
Name, Last Name:
Hospital:
Preferred Phone#:
Alt.Phone#:

Do you need information about an estimate for a specific procedure but do not need to consult a DVM?	No	Yes	Please describe:
Do you need to discuss medical management or next steps for this patient?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please fill out the rest of this form and send along with pertinent medical notes and test results to vhcrefdvm@missouri.edu *please note we do not have access to results of any tests sent to the VMDL

Case summary *(please include relevant history, abnormal PE or diagnostic findings)*

Please list any specific question(s) you may have

***** If the patient needs an appointment please have the Owner call 573-882-7821 to schedule and confirm the appointment. *****