ANIMAL EYE CLINIC

Charles M. Stuhr, DVM, DACVO
783 Danbury Road
Wilton, CT 06897
Phone#1: 203-762-9399 Phone#2: 203-587-1224
Fax: 203-587-1226

REFERRAL FORM

CLIENT INFORMATION Date referred: _____

Client last name: _____ First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Work phone: (___) _____

PATIENT INFORMATION

Pet's name: _____ Species: Canine / Feline / Other

Breed: _____ Sex: M / F / MN / FS

Date of birth or age: _____

REFERRING VETERINARIAN INFORMATION

Veterinarian: _____ Phone: _____

Veterinary hospital: _____

HISTORY

Affected eye: OU / OS / OD Duration of problem: _____

Please describe the nature of the eye problem:

1) Present condition: _____

2) Tentative diagnosis given to client: _____

3) Diagnostic test(s) performed and results: _____
(Include lab work if appropriate for diagnosis or anesthesia)

4) Current Medications and dosages _____

5) Significant past medical history: _____

We appreciate your referral!