Fax Number: (315) 478-3161 **Email: stackteam@stackvethospital.com**

Laser Referral Form

Referring Veterinarian: _____ Date: _____

Referring Hospital: _____

Hospital Phone #: _____ Fax #: _____

Client Name: _____ Telephone # _____

Patient Name: _____ Sex: _____ Age: _____

Species: _____ Breed: _____ Weight: _____

Reason for Laser Referral:

_____

_____

Sites for Laser Treatment:

_____

_____

_____

Radiographs: Yes No (circle one)
If yes, radiographic findings: _____

_____

_____

Current Medications:_____

_____

Rabies Vaccine Date (Needed for tx): _____

Comments: _____

_____