

Pet Wellness Center and Gentle Pet Vet

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DACVIM-Neurology, DACVB

REFERRAL FORM

Referring veterinarian information:

Name _____

Clinic _____

Address _____

City/State/Zip _____

Phone _____ **FAX** _____ **EMAIL** _____

Client Information:

Name _____

Phone _____

Fax # or address for sending information and questionnaire

Patient Information:

Name _____

Breed _____

Age _____ **Sex** _____

Please list any current medical problems, treatments, and medications:

Brief History of Problem:

Recent vaccinations and dates _____

Please send this form and a copy of the patient's relevant medical records via fax or by mail to the address listed above. We will send you a copy of any test results or discharge instructions given to your client after their appointment. Thank you for your referral.