



Referral Form

Today's Date _____

Owner _____ Pet's Name _____

Address _____

City _____ State _____ Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____

Species _____ Breed _____ Age _____ Sex _____

Gary Riggs, DVM, DABVP:
Avian

1053 S. Cleveland-Massillon Rd.
Akron Ohio 44321

1.877.NC XOTIC (1.877.629.6842)
ER: 330-666-2976

Fax: 330-825-0090

Past Pertinent History _____

Present Problem _____

Past Treatment _____

Current Medications – indicate dose & duration _____

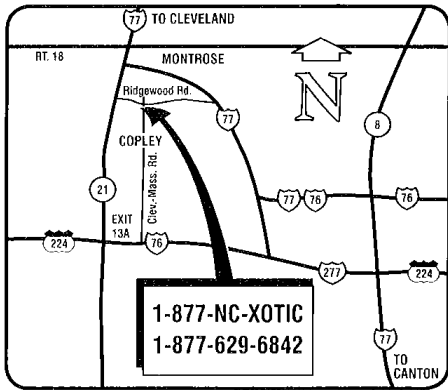
Diagnostic Materials Being Sent _____

Referring Dr. & Clinic _____

Address _____

Ph _____ Fax _____ E-Mail _____

Preferred Method of Communication: Phone Fax Letter E-Mail



www.exoticpetvets.com



Please send all radiographs
(labeled with clinic name), copies
of current records and all test
results with the owners.

Thank You!