ANIMAL EYE CLINIC

• Michael E. Paulsen, DVM, MS • Diplomate, American College of Veterinary Ophthalmologists •

OPHTHALMOLOGY REFERRAL FORM

Attention Referring Veterinarian and Staff,

To better serve you and your clients' needs, we ask that you complete this form when referring patients. Once completed, please fax to our office at **817-478-3692**. There is no need to fax the patient's entire medical record. If you have any questions or concerns please feel free to contact our office.

Sincerely,
Dr. Michael Paulsen and the Staff of the Animal Eye Clinic

CLIENT INFORMATION		RDVM INFORMATION	
Owner's Name:		**Hospital Name:**	
Home Phone:		**Referring DVM:**	
Work Phone:		**Referring Phone:**	
		Referring Fax:	

Patient Name	Breed	Sex	Age/DOB	Weight

Symptoms / Brief History:

_____

_____

_____

_____

Duration of Problem: _____

Diagnostics performed: (Tonometry, Fluorescein Stain, Schirmer Tear Test)

_____

_____

Current Medications:

_____

_____

_____

Health Concerns: (Diabetes Mellitus, Heart Murmur, Seizures, Renal Insufficiency)

_____

Recent Labwork (within 6months): ___ yes ____ no *If yes, please fax with this form*

Status of Appointment: ___ Emergency ___ This Week ___ Routine

• Please have client call our office to set up Appointment •

Fax to 817-478-3692

• 5820 West Interstate 20 Hwy • Arlington, Texas 76017 •
• Office: 817-483-8762 • Metro: 817-572-0163 • Fax: 817-478-3692 •
• www.TexasEyeVet.com •
• Located in: I-20 Animal Medical Center •

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