



INTERNAL MEDICINE CONSULT FORM

CLINIC NAME: _____ DOCTOR'S NAME: _____

CLIENT NAME: _____ PET'S NAME: _____

Date: _____ Breed: _____ Age: _____ Sex: _____

PREFERENCE OF RESPONSE (Check One): Phone _____ E-mail _____ Fax _____

(Circle One) Phone# / E-mail Addr / Fax#: _____

LAB WORK DONE AT PHOENIX ACCESSION NUMBER: _____

CONSULTATION QUESTION: _____

RECENT HISTORY:

Vomiting Diarrhea _____

Respiratory Changes _____

Lameness Weakness _____

Weight Loss _____

Inappetance _____

PU/PD _____

PERTINENT PAST HISTORY: _____

PHYSICAL EXAM FINDINGS:

Temp _____ Body Wt _____ HR/Pulse _____ Resp Rate _____

Mentation: _____

Mucous Membranes/Oral Cavity: _____

Integument: _____

Lymph Nodes: _____

Thorax: _____