370 Greenbrier Dr. Suite B
Charlottesville VA 22901
434-202-2987
www.vavetspecialists.com

Oncology Referral Form

Date: _____

The goal of an oncology consultation is to discuss treatment options and prognosis for a specific type of cancer. In order to provide the best medical care for our patients and their families, a diagnosis of cancer, completed referral forms (by DVM or LVT familiar with the case), and receipt of all medical records/documentation are required prior to scheduling.

Patient Information (please assist us by printing):

Patient's Name: _____
Species: _____ Breed: _____ Age: _____
Color: _____Sex: _____Weight: _____

Client Information

Owner's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary number: _____ Alternate number: _____

Referring Veterinarian Information

Primary Care Veterinarian: _____
Hospital Name: _____
Phone: _____ Fax: _____
Name of person completing this form: _____

Please answer the following and attach appropriate documentation.

The primary reason for the referral is related to a recent diagnosis of cancer. *Please select one of the following.*

- Official, finalized pathology report (cytology, histopathology, PARR, flow cytometry, etc.) **All in-house samples must be submitted for interpretation by a pathologist prior to oncology referral.* *Diagnosis: _____
- Urinary bladder mass and detection of mutated cells on urine Cadet BRAF analysis, suggestive of urothelial carcinoma.
- Aggressive, monostotic lesion affecting the metaphyseal region of the appendicular skeleton (e.g. proximal humerus, distal radius, distal femur, proximal tibia) in large or giant dog, suggestive of osteosarcoma

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Is this patient current on core vaccines? ☐ Yes ☐ No
Rabies Date: _____
DHLPP Date: _____
FDV Date: _____
Has this patient had a heartworm test within the past 12 months? ☐ Yes ☐ No
Date: _____
Is this patient stable? *Please call if this is an urgent referral.* ☐ Yes
Is this patient currently receiving Apoquel? ☐ Yes ☐ No
Is this patient currently eating a raw diet or a grain-free diet? ☐ Yes ☐ No

Please select if any of the following additional diagnostics have been done within the last 6 months and forward all results/records:

☐ CBC/chemistry ☐ Urinalysis ☐ FeLV/FIV test ☐ Chest x-rays ☐ Abdominal ultrasound
☐ 3D imaging (CT or MRI) ☐ None ☐ Other: _____

Please list all medications this patient is currently receiving (drug name, dose, frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Does this patient have other significant medical problems that are not well-controlled? *Examples: hyperthyroidism, diabetes mellitus, heart failure, etc.* ☐ Yes ☐ No
If yes, please explain: _____
_____

Is this patient currently under the care of another oncologist or specialist?
☐ **Yes** ☐ **No** If yes, please name hospital(s): _____

Please provide any additional information that may be helpful in facilitating the referral of this patient:

_____
_____
_____
_____
_____
_____