



Referral for Specialist Surgery

Charles A Kuntz, DVM, MS, DACVS, Fellow of Surgical Oncology, Specialist of Small Animal Surgery

Please fast your pet from 10 pm the night before the appointment unless directed otherwise.

Reason for referral: _____ Date: _____
 Referring Hospital Name: _____ Dr.: _____
 Phone: _____ FAX: _____
 Hospital E-mail: _____
 Referred Client Name: _____
 Client Address: _____
 _____ Post Code: _____
 Client Telephone: _____ Client mobile: _____
 Patient Name: _____ Age: _____
 Species: _____ Breed: _____ Sex: _____
 Presenting Problem: _____
 History: _____

Physical Examination: _____

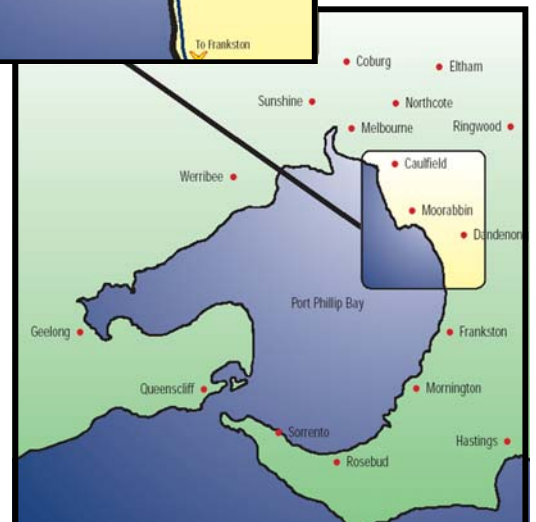
Presumptive Diagnosis: _____

Therapy Administered Prior to Referral: _____

Referred for: (diagnosis, recommendations, treatment) _____



SARC



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