UTCVM ORTHOPEDIC SERVICE

Consultation Request Form *(NOT FOR REFERRAL)*

DIRECT FAX NUMBER: (865) 974-0174 **EMAIL** *(preferred)*: **utvetortho@utk.edu**

DATE FAXED: ______________________ **# OF PAGES FAXED:** ______________________

Veterinarian: ______________________ Clinic Name: ______________________

Fax: ______________ Phone: ______________ Email: ______________________

Owner(name): ______________________ Animal (name): ______________________

Species: ❑ Dog ❑ Cat Color: ______________ Sex: ❑ M ❑ M/C ❑ F ❑ F/S Weight: ______________

Breed: ______________ Age/DOB: ______________ Rabies Vacc. Date: ______________

Diagnosis *(attach biopsy and/or cytology reports)*: ______________________

Request:

❑ **Orthopedic Surgery Consultation** ❑ **Orthopedic Medical Management Consulation**

Please check below any diagnostic tests already performed and attach the results:
(Please do not fax entire medical record)

❑ CBC ❑ Chemistry Profile ❑ Cytology: ______________

❑ UA ❑ Radiographs *(date)*: ______________

❑ CT Scan/Ultrasound *(date)*: ______________

Current medications:

Other pertinent medical history:

Questions you would like addressed:

In an effort to make sure consultations are competed in a timely manner, please email radiographs and any pertinent test results to ***utvetortho@utk.edu*** *with this completed form.*

UPDATED 04/27/20 © University of Tennessee