

NUTRITION REFERRAL FORM

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Before a consultation with the UTCVM Nutrition Service can be completed, we must receive this **Nutrition Referral Form** (completed by the referring veterinarian), the **Diet, Activity & Household History Form** (completed by the owner), and a **chemistry** and **urinalysis** from the last 6 months (including all other pertinent medical records).

Submitting a referral to the UTCVM Nutrition Service signifies the listed referring veterinarian has an established veterinarian-client-patient relationship (VCPR) for this patient and authorizes members of the UTCVM Nutrition Service to perform remote consulting directly with the patient owner.

Patient Name:		Species:		Breed:		Today's Date:	
Sex:	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> SF <input type="checkbox"/> NM	Age:	<input type="checkbox"/> years <input type="checkbox"/> months	Color:	Current Wgt: (in kg)	Date measured:	Ideal Wgt: (in kg)
Owner:		Body Condition Score:		9 pts scale	Muscle Condition: <input type="checkbox"/> Normal <input type="checkbox"/> Mild Wasting <input type="checkbox"/> Moderate Wasting <input type="checkbox"/> Severe Wasting		
Street Address:		Home Phone:		Other Phone:			
City:	State:	Zip Code:	Email Address:				

PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS AND LAB RESULTS

Vaccination Status: Canine DA2P Feline FVRCP Rabies 1 yr 3 yr _____ Other _____
 Medical reason precluding rabies vaccination (if any): _____
 Flea/Tick Preventatives: _____

Reason for Referral:	Referral Type: <input type="checkbox"/> Critical Care Consult (including feeding tube and/or parenteral nutrition plans) <input type="checkbox"/> Commercial Diet Plan <input type="checkbox"/> Homemade Diet Plan <input type="checkbox"/> Weight Loss Plan (remote) <input type="checkbox"/> Veterinary Obesity Center (in-person) <input type="checkbox"/> Unsure/ Other: _____
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Animal Temperament:

Pertinent History: (i.e., Diagnostic results, physical exam notes, and summary sheets for at least 6-12 months prior to the consult request)

Pertinent Lab Results: (Please send a complete copy of results and reference intervals from any lab, including UT, to ensure proper patient identification. ALL requests must include chemistry, and urinalysis completed within 6 months prior to the consult request.)

Current Medication/Treatment: (If complex/ongoing condition, please send medical records showing meds/treatment)	Estimate Given: <input type="checkbox"/> yes <input type="checkbox"/> no \$
Referring Veterinarian: First _____ Last _____	INCLUDED MANDATORY DIAGNOSTICS:
	<input type="checkbox"/> Chemistry (within last 6 months) <input type="checkbox"/> Urinalysis (within last 6 months)
Veterinary Clinic:	OTHER INCLUDED DIAGNOSTICS:
Address	<input type="checkbox"/> Urine culture <input type="checkbox"/> Fecal
City: _____ State: _____ Zip Code: _____	<input type="checkbox"/> UPC <input type="checkbox"/> Bile acids
Phone: _____	<input type="checkbox"/> PLI <input type="checkbox"/> Histopathology
E-Mail: _____	<input type="checkbox"/> TLI <input type="checkbox"/> Imaging reports
Fax: _____	<input type="checkbox"/> B12 <input type="checkbox"/> Other
Primary Veterinarian: _____ <input type="checkbox"/> Same as Referring Veterinarian	<input type="checkbox"/> Folate
Primary Veterinarian Phone: _____	