



TWIN CITIES

VETERINARY BEHAVIOR

REFERRAL SERVICE, LLC

Date _____

BEHAVIOR REFERRAL FORM

CLIENT AND PATIENT INFORMATION

Client Name _____ Pet Name _____
 Address _____ Species _____
 City, State, Zip _____ Breed _____
 Phone (Home) _____ Sex M MC F FS
 Phone (Work) _____ Age / DOB _____
 E-mail Address _____ Weight _____ pounds/kgs

REFERRING VETERINARIAN INFORMATION

DVM Name _____ Phone _____
 Clinic / Hospital _____ Fax _____
 Address _____ Email _____
 City, State, Zip _____

PRIMARY COMPLAINT / HISTORY

DIAGNOSTICS / TREATMENT

Please return this form along with **LAB TEST RESULTS** and the **COMPLETE MEDICAL RECORD** using the contact information listed below. I will then contact the client to schedule their pet's appointment.

TWIN CITIES VETERINARY BEHAVIOR REFERRAL SERVICE, LLC  **CHRISTOPHER L. PACHEL, DVM**

P.O. Box 10598 | White Bear Lake, MN 55110 | T: (651) 592-1740 | F: (651) 286-3215 | drpachel@TCVetBehavior.com