



Veterinarian Referral Form

1480 S County Trail, East
Greenwich, RI 02818
P: 401-886-6787
F: 401-886-8998
E: reception@osvs.net

Date: _____

Service to which referred (circle one):

ER / Critical Care Internal Medicine Surgery Oncology Neurology Ophthalmology
Cardiology (Outpatient / Consult) Radiology (Outpatient Ultrasound / i131) Avian / Exotics

Specialty Services

Critical Care

Alexa Splittstoesser, DVM
Ida Kornevi, DVM, MSc, MRCVS
Terry Hallowell, DVM,
DACVECC
Marisa Stone, DVM, DACVECC

Internal Medicine

Gary Block, DVM, MS, DACVIM
Rebecca Kessler, DVM, DACVIM
Elizabeth Kubas, DVM, DACVIM
Lauren Monhait, DVM
Caylie Voudren, MS, DVM,
DACVIM
Sara Wilkes, DVM

Surgery

George Coronado, DVM, MS,
DACVS
S. Christopher Ralphs, DVM,
DACVS
David C. Sweet, VMD, DACVS

Oncology

Caleb Alexander, DVM, DACVIM
Kellie Snider, DVM

Neurology

James P. Cellini, DVM, DACVIM
Lauren E. Marini, DVM, DACVIM

Ophthalmology

Marcia Aubin, DVM, MS, DACVO

Cardiology

Adam Kane, DVM, DACVIM

Radiology

Susan M. Newell, DVM, MS,
DACVR

Avian/Exotics

Lucy H. Spelman, DVM,
DACZMA

Client Name: _____ Patient Name: _____

Client Email: _____ Tel #: _____

Address: _____

Species: _____ Breed: _____ Age: _____ Color: _____

Patient History Sex: M / F Spayed/Neutered?: Y / N

Diagnosis / Chief Complaint: _____

Significant History / Treatments: _____

Diagnostics Performed: _____

(Please send radiographs & copies of test results with client or fax copies with referral form)

Are radiographs being sent? Y / N

Tests pending (list): _____

Vaccination History: _____

Current or Recent Medication or Therapy (include dosage/duration): _____

Referring Veterinarian Information:

Clinic: _____ Referring Veterinarian: _____

Phone: _____ Fax: _____ Email: _____