VIRGINIA Veterinary SPECIALISTS
370 Greenbrier Drive Suite B
Charlottesville, VA 22901
O: 434-202-2987
F: 434-260-3822

Oncology Referral Form

Date: _____

The goal of an oncology consultation is to discuss treatment options and prognosis for a specific type of cancer. In order to provide the best medical care for our patients and their families, a diagnosis of cancer and completed referral forms are required prior to scheduling.

Patient Information (please assist us by printing):

Patient's Name: _____
Species: _____ Breed: _____ Age: _____
Color: _____ Sex: _____Weight: _____

Client's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Primary Care Veterinarian: _____
Hospital Name: _____
Phone: _____ Fax: _____

Please select one of the following:

☐ This patient has a confirmed diagnosis of _____ made via official cytology or histopathology. Please attach the pathology report.

☐ This patient has a mass in the urinary tract and has been diagnosed with urothelial carcinoma/transitional cell carcinoma via detection of mutated cells on urine Cadet BRAF analysis. Please attach the BRAF results.

☐ This patient has a lytic/proliferative bone lesion with a history and signalment suggestive of osteosarcoma. Please attach the x-rays and radiology report.

☐ This patient has another finding that is highly suggestive of malignant neoplasia. Please provide a brief description and *call to discuss* prior to referral: _____
_____

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Please respond to the following statements:

The *primary* reason for referral is related to a recent diagnosis of cancer. ☐ Yes ☐ No
This patient is up-to-date on vaccines and monthly preventatives. ☐ Yes ☐ No
This patient has had a negative heartworm test within the past 12 months. ☐ Yes ☐ No
This patient is otherwise stable. ☐ Yes ☐ No
Please *call to discuss* if you answered "no" to any of the above questions.

This patient is currently under the care of another oncologist or specialist. ☐ Yes ☐ No
This patient is currently receiving Apoquel. ☐ Yes ☐ No
This patient is currently eating a raw diet or a grain-free diet. ☐ Yes ☐ No
This patient has other significant medical problems that are not well-controlled. Examples: hyperthyroidism, diabetes mellitus, heart failure, etc. ☐ Yes ☐ No
Please *call to discuss* if you answered "yes" to any of the above questions.

Please select if any of the following additional diagnostics have been done within the last 6 months and forward all results/records:

CBC/chemistry ☐ Urinalysis ☐ FeLV/FIV test ☐ Chest x-rays ☐ Abdominal ultrasound ☐
3D imaging (CT or MRI) ☐ PARR or flow cytometry ☐ Other ☐ _____

Please list all medications this patient is currently receiving (drug name, dose, frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please provide any additional information that may be helpful in facilitating the referral of this patient: _____
_____
_____
_____
_____
_____
_____

Thank you for your referral to Virginia Veterinary Specialists
www.vavetspecialists.com