

**Small Animal Hospital Appointment Request Form**

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| **Appointment Details** | **Please fill in ALL details to ensure a rapid and effective response** |
| **Appointment Type**  **RED – LIFE THREATENING 🞏**  **(EMERGENCY SAME DAY APPOINTMENT)**  **ORANGE - URGENT 🞏**  **(APPOINTMENT WITHIN 72 HRS)**  **GREEN – NORMAL 🞏**  **(NEXT AVAILABLE APPOINTMENT**  **ADVICE 🞏 ESTIMATE 🞏**  Note that ORANGE and RED cases are charged higher consultation prices and the decision to use these options may have to be justified by the referring vet to an owner’s insurance company. | **Presenting Complaint** |
| For RED cases please complete the EMERGENCY INFORMATION section and phone the Small Animal Hospital (**0141 330 5848 and choose hidden option 9**) to arrange immediate referral.  For ORANGE and GREEN cases please provide a short referral letter with recent treatment and test results. A member of clinical staff will contact your practice to arrange an appointment at the hospital.  In ALL cases please send a copy of the case history, blood tests and radiographs to the hospital to help the patient and reduce the number of tests that need repeating. | |
| **Referral Letter Attached** **🞏**  **History Attached** **🞏**  **Blood Results Attached** **🞏**  **Radiographs Attached** **🞏** | |
| **Clinical Service Required (please tick)**  **Behavioural 🞏**  **General Medicine 🞏**  **Neurology 🞏 Oncology 🞏**  **Ophthalmology 🞏 Orthopaedics 🞏**  **Pain Management 🞏 Physio/ Hydrotherapy 🞏**  **Radiotherapy (unavailable) 🞏 Soft tissue surgery 🞏** | |
| Owner Details |  |
| Client Surname |  |
| Client First Name |  |
| Client Title |  |
| Address |  |
| Post Code |  |
| Contact Telephone |  |
| Email address |  |
| Special needs |  |
| Patient Details |  |
| Animal name |  |
| Species |  |
| Breed |  |
| Colour |  |
| Sex |  |
| Age or DOB |  |
| Insurance Details |  |
| Insured (Yes/No) |  |
| Insurance Company |  |
| Policy Number |  |
| Referring Vet Details |  |
| Vet Name |  |
| Practice name |  |
| Practice address |  |
| Practice email |  |
| Practice telephone |  |
| **EMERGENCY ASSESSMENT** |  |
| Collapse |  |
| Paresis / paralysis |  |
| Cardiorespiratory problem |  |
| Haematological problem |  |
| Trauma |  |
| Seizures |  |
| Spinal |  |
| Recent treatments |  |
| Recent anaesthesia |  |
| Other problems |  |

**Please note that if a history is not attached we may not be able to assess your referral.**

**Please email completed form to:** [**sah-reception@glasgow.ac.uk**](mailto:sah-reception@glasgow.ac.uk)