

# Internal Medicine Consult Request

Date:

## Patient Information

Patient ID/Number:  
(if seen at VMTH before)  
Name:

Age:                     yr                     Estimated  
                                   mo                    age?

Sex:                     FS                     MN  
                                   FI                     MI

Breed:

Species                 Canine                     Feline

## Owner Information

Name:

Last Name:

Phone#:

Alt.Phone#:

## Veterinarian Requesting Consult Information

Name, Last Name:

Hospital:

Preferred Phone#:

Alt.Phone#:

*\*\*Consults will be answered within 1 to 2 business days  
If you have not received a phone call after 2 business days  
please call the hospital (573) 882-7821 \*\**

Does this patient already have an appointment with the internal medicine team?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes – when? _____ If no – do they need help making one? Y/N
Do you need information about an estimate for a specific procedure but do not need to consult a DVM?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Please describe:
Do you need to discuss medical management or next steps for this patient?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, please fill out the rest of this form and send along with pertinent medical notes and test results to <a href="mailto:yhcrefdvm@missouri.edu">yhcrefdvm@missouri.edu</a> <i>*please note we do not have access to results of any tests sent to the VMDL</i>

Case summary *(please include relevant history, abnormal PE or diagnostic findings)*

Please list any specific question(s) you may have