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Referring Vet	Date
Referring Clinic	Client
Phone	Patient
Fax	Breed
	Age Weight
	Sex (circle one) Male Female
	(circle one) Neutered Spayed

Brief History of Issue

Diagnostic Tests Run (attached a copy of results)

X-rays _____ Blood Work _____ Urinalysis _____ Ultrasound _____ Other _____

Conventional Diagnosis/Diagnoses

TREATMENT OPTIONS

Please indicate specific treatment modalities if applicable.

- Acupuncture, Chinese Herbs, Food Therapy
- Nutritional Consult
- Homeopathic Consult
- Chiropractic
- Therapeutic Nutritional Supplementation
- Appropriate combination of above