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Behaviour problems may arise both directly and indirectly as a result of concurrent or previous medical problems. Veterinary involvement is therefore essential in eliminating organic causes of the problem and prioritising the diagnostic and treatment strategy to be used in any given case. In order to safeguard the welfare of your patient and indicate your approval of referral, please complete the following form. Please note that until a case is released to another veterinary surgeon then you, as the client's normal veterinary surgeon, remain responsible for the treatment, advice and any prescriptions given.

Referring / Contact Veterinary Surgeon \_\_\_\_\_ MRCVS

Practice Name \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Post Code \_\_\_\_\_

Client Name: \_\_\_\_\_

Species/breed \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Post Code \_\_\_\_\_

Tel: (inc. STD code) \_\_\_\_\_

Fax: \_\_\_\_\_

Patient name \_\_\_\_\_

Age \_\_\_\_\_ Sex (inc.neuter status) \_\_\_\_\_

Tel: (inc. STD code) \_\_\_\_\_

Brief details of behaviour problem

Date first noticed \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has euthanasia been considered? \_\_\_\_\_

I hereby acknowledge my approval for the client described overleaf to be referred for management of the current behaviour problem to:

Referral Practice Name: \_\_\_\_\_

Case reference number \_\_\_\_\_

**Medical history:**

Date of last health check \_\_\_/\_\_\_/\_\_\_

Weight \_\_\_\_\_ Kg

Please indicate if there are current or previous health problems concerning the following and attach appropriate details:

- |   |  |
|---|--|
| <input type="checkbox"/> Allergic reactions       | <input type="checkbox"/> Orolaryngeal region |
| <input type="checkbox"/> Cardiovascular system    | <input type="checkbox"/> Respiratory system  |
| <input type="checkbox"/> Endocrinological system  | <input type="checkbox"/> Sensory systems     |
| <input type="checkbox"/> Muscular skeletal system | <input type="checkbox"/> Skin and adnexae    |
| <input type="checkbox"/> Nervous system           | <input type="checkbox"/> Urogenital system   |

Please provide details of any blood screens performed including specific organ function tests and assays

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Date and purpose of any general anaesthetics

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Details of any ongoing medical conditions or treatments

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Summary medical history / medical records attached (delete as appropriate)

Further information attached Yes / No

Signed: \_\_\_\_\_ MRCVS

Date \_\_\_/\_\_\_/\_\_\_

I ....., the owner of the above named animal, consent to the disclosure of clinical information regarding my pet by my veterinary surgeon for the purposes of referral.

Signed \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_