



Phone (719) 266.6400 • Fax (719) 260.0823

Animal Anesthesia & Pain Management Center

Hospital Name _____

Doctors Name _____ **Reference #** _____

Patient _____

Owner _____

Age _____ **Breed** _____

Gender M F MC FS **Weight** _____ Lbs Kg

Species Canine Feline Equine Ferret Rabbit Bird

Other _____

Underlining Medical Problem Cardiac Liver Renal GI Ocular Integumentary Pulmonary

Endocrine Neurologic Other? _____

Current problem for which consultation is requested

Patient is receiving what drugs currently, including dose and frequency associated with the drug

Problems current or previous with this therapy

	Select	Response	Available	Response Time	Price
Select Service	<input type="checkbox"/>	Web	M-F 9am-5pm	Submit by 5pm, response by 6am following day	\$25
	<input type="checkbox"/>	Fax	M-F 9am-5pm	Submit by 5pm, response by 6am following day	\$30
	<input type="checkbox"/>	Phone	M-F 8am-5pm	Submit by 5pm, response by 6am following day	\$35

All times are mountain standard time (MST)