




Veterinary Office/ Veterinarian Card Here

**Specialty Services:**


**Acupuncture & Integrative Medicine**

 Dawn Greenberg, DVM, CVA


**Cardiology Department**

 Keith Blass, DVM, DACVIM  
(Cardiology)


**Dentistry Department**


 Donald DeForge, VMD (Practice limited to Dentistry)


**Oncology Department**

 David Hunley, DVM, DACVIM  
(Oncology)


**Surgery Department**

 Ariel Kravitz, DVM (Practice limited to Surgery)

 Matthew Raske, DVM, DACVS-SA

 Jessica Baron, DVM, DACVS-SA

**Rehabilitation Department**

 Victoria L. Kearns, LVT, CCRP, NCM, OACM



As a specialty center, we must comply with certain obligations that are inherent with the services we are providing. If you have a referring veterinarian, we will not under any circumstances, nor will any of our affiliates (West Hills Animal Hospital, West Hills East Veterinary Clinic, Locust Valley Veterinary Clinic, or Oyster Bay Animal Hospital) provide any elective services or routine care.

# Referral Form

Please complete the form in its entirety. Please either fax to 631-498-6456 or email to [csr@goldcoastcvc.com](mailto:csr@goldcoastcvc.com).

Date: \_\_\_\_\_ RDVM: \_\_\_\_\_

DVM Phone: \_\_\_\_\_ DVM Fax: \_\_\_\_\_

DVM Email: \_\_\_\_\_

***Client Information:***

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

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

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

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

***Patient Information:***

Pet's Name: \_\_\_\_\_ Species/Breed: \_\_\_\_\_

Pet's Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_

***Presenting Problem:***

\_\_\_\_\_

***Pertinent History/Current Treatments/Current Medications:***

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please attach any medical history, laboratory and or diagnostic data and any current medication lists. If there are any radiographs please send them to [csr@goldcoastcvc.com](mailto:csr@goldcoastcvc.com).