University of Tennessee, W.W. Armistead Veterinary Teaching Hospital

REFERRAL FORM - NUTRITION

2407 River Drive, Room C247, Knoxville, TN 37996-4544 Tel: 865-974-8387, Fax: 865-974-5599, utvns@utk.edu



College of Veterinary Medicine

Today's Date:	UTCVM VTH PTN:	UTCVM VTH PTN:		
REFERRING VETERINARIAN INFORM	MATION			
DVM Name:	Hospital Name:			
Address:	·		Tel:	
City:		State:	Fax:	
Email:				
PATIENT INFORMATION				
Name:	Species:		Color:	
Breed:	Sex:	Sex: Body Condition Score: 5/9 pt sca		
DOB: Age:	Current Wgt:	lbs * /kg *	deal Wgt: lbs * /kg *	
OWNER INFORMATION				
Name:	Email:			
Address:			Tel:	
City:		State:	Zip:	
Reason for nutrition consult request:				
Patient Medical History: (please include all medications and copies of relevant lab work - fax or email)				
Patient Dietary History: (For commercial foods, please include brand, type, and form (canned/dry))				
Primary Diet:				
Amount fed per day:	Times fed per day:			

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Date:	Patient Name:	UTCVM VTH PTN:		
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Other foods/treats/supplements:				
Recent dietary changes:				
If a novel protein diet is requested. please included a detailed diet history of commercial and homemade foods:				

Disclaimer: Recommendations made by the University of Tennessee College of Veterinary Medicine Nutrition Service are made in consultation with the referring veterinarian. The referring veterinarian retains primary case responsibility and may or may not choose to follow the recommendations provided by UTCVM-NS.