

Advancing Cancer Treatment and Research 

RDVM Consulting Form

Assigned to: _____ Consult #: _____

Requested Date: _____ Time: _____ A.M. / P.M. Issued Date: _____ Time: _____ A.M. / P.M.

Veterinarian: _____ Clinic name: _____

Address: _____

Phone: (home) _____ (work) _____

(mobile) _____ (fax) _____

email: _____

Time(s) **NOT** available: Time: _____ A.M. / P.M. from Time: _____ A.M. / P.M.

Client's name: _____

Animal's name: _____ Age: _____ Breed: _____

Sex: M / F Castrated Spayed Intact

Diagnosis: _____

Office use only:

Faxes to be sent: _____ Return Date: _____ Time: _____ A.M. / P.M.

Messages Left: _____

Please return to Kathy Paris: (email) kathryn.paris@colostate.edu, or (fax) (970) 297-1254