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Referral Form

Primary Care Veterinarian: Dr. _____

Clinic Name: _____

Clinic Email: _____

Clinic Phone: _____ Clinic Fax: _____

How would you like reports sent to your office: Email / Fax

Does your clinic have the ability to measure intraocular pressure: Yes / No Tonovet/Tonopen

Owner:

Name: _____

Address: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Patient:

Name: _____ Species: _____ Breed: _____ Weight: _____

Sex: Male / Female Castrated / Spayed

Date of Birth: _____ Color: _____ Temperament: _____

Reason for Referral:

Reason for Referral/Provisional Diagnosis: _____

History and underlying comorbidities:

Ophthalmic Findings:

Current Treatment/Medications:

If lab work has been performed in the last three months please attach copies