

AVL's Consultation Form

Please fill out the following form for each patient you are requesting a consult on.
Consultations will be given Monday- Friday 7am to 5pm. Please allow up to 24 hours once
the information is received to be contacted regarding your case. Fax the completed form to
the lab at (314) 645-1953.

Date: _____ Requesting Clinician(s): _____

Hospital: _____ Consultation via phone: Written Consultation:

Contact Number : _____ Date and Hours Available: _____

Patient Information:

Patient Name: _____ Accession Number(s): _____

Sex: F FS M MN Age: _____ Breed: _____ Wt: _____

First Consult: Follow-up consultations for ongoing case management:

Medical Information:

Pertinent Medical or Cancer

History: _____

Past Medical

History: _____

Reports included: CBC Serum Chemistry U/A Biopsy Cytology

Regional lymph node evaluation (please attach results) Yes (Biopsy or Aspirate) No

Current drug therapy and/or response to previous medications: _____

Diagnostic imaging: CT/MRI US

Radiographs:

Thoracic

Abdominal

Other: _____

Summary of imaging findings: _____

Diagnosis: _____

Please contact the lab at (314) 645-1933 regarding any questions. We will submit laboratory work for each accession number listed above to the consultant.

AVL
1902 McCausland Ave.
St. Louis, MO 63144