

# Avian/Exotic FAX Consultation Service

**Patient Information:**

Date of Request \_\_\_\_\_ Time \_\_\_\_\_

Bird  Reptile  Exotic Mammal

Client \_\_\_\_\_

Species (common name) \_\_\_\_\_ Pet Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**Note: A Consultation Request Form Must Be Included**

**Presenting complaint:**

**Clinical History:** Source of patient, length of ownership, other pets in household. Describe housing, environment, sanitation practices. Completely describe diet (not just good diet)-percentage of various foodstuffs plus any supplements used.

**Current and previous drug therapies,** with notes on formulations, dosages, and response to therapy.

**Physical Exam Findings**

**Weight \_\_\_\_\_ g.**

**Diagnostic tests run:** (check tests done) and include copies of data:

- CBC  Chemistries  Fecal Parasites  Gram Stains  Exfoliative cytology  Bacterial culture  Fungal culture  Urinalysis
- Chlamydia Antigen ELISA  Chlamydia FA  Chlamydia EM  Chlamydia Cell Culture/Embryo  Chlamydia Titer
- Chlamydia cytology  Acid Fast Stain  Tracheal Wash  Ultrasound  Biopsy  Necropsy  Laparoscopy  Viral titers
- Ultrasound

**Tentative Diagnosis:**

**Specific Questions to be answered:**

# Avian/Exotic FAX Consultation Service for Veterinarians

## FAX (916) 405-3367

Voice (877) 521-6004 or (916) 933-0898

August 2004

Alan M. Fudge DVM, Dip ABVP-Avian  
President

*Please check one:*

**Service Requested** (specify consult type and payment method)

**1.      FAX Consultation or Reply by Email**

**Payment options**

Charged to VISA/MC \$45.00  
Card # \_\_\_\_\_ Exp date \_\_\_\_\_

Billed to CalAvian Lab Account \$50.00, Acct # \_\_\_\_\_  
No Charge if associated with lab work performed by Calif Avian Lab  
Please list accession#s \_\_\_\_\_

**2.      Phone Consultation**

**Payment options**

Charged to VISA/MC \$55.00  
Card # \_\_\_\_\_ Exp date \_\_\_\_\_

Billed to CalAvian Lab Account \$60.00, Acct # \_\_\_\_\_  
No Charge if associated with lab work performed by Calif Avian Lab  
Please list accession#s \_\_\_\_\_

Hospital Name \_\_\_\_\_

Dr. Requesting Consult \_\_\_\_\_ email address \_\_\_\_\_

Hospital FAX (\_\_\_\_\_) \_\_\_\_\_ Alternate phone# \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Best time to call \_\_\_\_\_ Time zone \_\_\_\_\_

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

City \_\_\_\_\_ State/Prov \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**For all consults, please fill out the  
accompanying case history form.**