ALL CREATURES
Veterinary Nutrition Consulting

Meri Stratton-Phelps, DVM, MPVM
Diplomate ACVIM (LAIM), ACVN

VETERINARY NUTRITION CONSULT REQUEST FORM

TO BE COMPLETED BY VETERINARIAN

Please Return to Dr. Meri Stratton-Phelps at:

3407 Millbrook Court

Fairfield, CA 94534

This form can be faxed to:

916-244-2665

Date: ______________________________

Veterinarian Name: ______________________________

Veterinarian Phone Number: ______________________________

Best time to call: ______________________________

E-mail Address: ______________________________

Veterinarian Address: ______________________________

____

Animal Name: ______________________________

Body Weight (lb) ______________(BCS) ______________

PATIENT INFORMATION

1. Client Name:______________________________
   First Last

2. Species: ______________ Breed: ______________ Age: ______________

3. Sex: M MC F FS
   (circle one)

4. Does the patient have evidence of muscle wasting? Yes No

5. Does the patient have evidence of fluid retention (peripheral edema, abdominal fluid accumulation, pulmonary edema)? Yes No

RECENT PATIENT HISTORY

1. When did the patient present to your clinic?

2. Please describe the presenting history of this patient (include dates)

3. Current active problem list:

MEDICAL HISTORY

Intravenous Catheter:

1. Type of intravenous catheter: ______________________________

2. Location of catheter: ______________ Date of catheter placement: __________

Current pharmacologic therapy:

1. Intravenous fluid therapy: ______________ ______________

Type of fluid Rate of administration

Additives to intravenous fluids:

a) ______________ b) ______________

c) ______________ d) ______________

2. Other medications (*please give dose, and rate of administration*):

a) ______________ b) ______________

c) ______________ d) ______________

e) ______________ f) ______________

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3. Primary laboratory abnormalities:
(*PLEASE SEND ALL LABORATORY REPORTS WITH CONSULT)

1) 2)

3) 4)

5) 6)

DIET HISTORY

1. Current and previous diets:

Current diets:

	Brand of food	Amount fed (cups)	Frequency of feeding	Dates fed
1.				
2.				
3.				

Previous diets:

	Brand of food	Amount fed (cups)	Frequency of feeding	Dates fed
1.				
2.				
3.				

2. Dietary supplements (including vitamins)

	Type of supplement	Amount fed (tsp./oz.)	Frequency of feeding	Dates fed
1.				
2.				
3.				

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3. Patient dietary preferences

Please list protein sources that the patient has previously consumed:

1.	2.
3.	4.
5.	6.

Please list protein sources that are NOVEL, and that the patient would consume:

1.	2.
3.	4.

Please list carbohydrate sources that the patient has previously consumed:

1.	2.
3.	4.
5.	6.

Please list carbohydrate sources that are NOVEL, and that the patient would consume:

1.	2.
3.	4.

WHAT ARE THE THERAPEUTIC GOALS OF THIS NUTRITION CONSULT?

1. The completed forms can be submitted by fax or e-mail. The consult will be completed once the Nutrition Consult Request Form and Diet History Form have been received.

2. Consults will usually be completed within 2-3 weeks of the time they are received. If your patient requires an emergency diet formulation or diet recommendations please note this request on the consult. An emergency fee of $50.00 will be added to the consultation charge.

3. Completed consults will be sent to you as a PDF file. A hard copy of the consult letter can be mailed by request. I will bill the client directly, unless the patient is being treated in-house. The charge for formulating or balancing a home cooked diet is between $175-$200. Additional charges will be incurred if the consult is required on an emergency basis, or if extensive client follow-up or diet reformulation is required. These prices are current as of February 1, 2018, but are subject to change in the future.

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