



DR. BETH GIBBINS, DVM, DIPLOMATE ACVO

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Client Name: _____ Client Contact number: _____

Pet Name: _____ Age: _____ Gender: F FS M MC

Species: Canine or Feline Breed: _____

Chief Complaint: _____

Previous Treatments/Eye Medications:

Duration of Symptoms:

Pertinent Medical History for Dr. Gibbins:

Current Findings:

RDVM Requests or Concerns:

Today's Date: _____	Referring Veterinarian: _____
Hospital or Clinic name: _____	Email: _____
Phone Number: _____	Fax: _____

Do you believe this to be an emergency? Yes or No

Please circle one regarding scheduling an appointment:	
Owner to contact AEC	or AEC to contact Owner

Please Fax or Email this form and any recent lab work
Fax: (877)540-6360 Email: birminghamaec@gmail.com