Animal Emergency & Specialty

"Compassionate 24-hour emergency & specialty vet care for your best friend!"

Today's Date: _____

Current Time: _____

PATIENT REFERRAL FORM

Referring Veterinarian/Hospital Information

Veterinarian Name:	Hospital Name:
Office Phone #:	Office Fax #:
Office Email:	Our office prefers records by ❑ Fax ❑ Email
Would you like to receive patient updates outside of office hours? ❑ Yes ❑ No If yes, please provide: Personal Cell #:	Personal Email:

Client Information

Client's Name:	
Home #:	Cell #:
Work #:	Email:

Pet Information

Pet Name:	Species? ❑ Dog ❑ Cat	Age/DOB:
Breed:	Color(s):	Sex: ❑ M ❑ M/N ❑ F ❑ F/S
Presenting Complaint:		
Current Patient Condition? ❑ Healthy ❑ Stable ❑ Critical ❑ Other:		Vaccination Status?
Reason for Referral? Other Relevant/Ongoing Medical Conditions?		
Diagnostics? (Please list all diagnostics performed and attach copies of the results.) Enclosures/Attachments? ❑ Lab Reports ❑ Radiographs ❑ ECG ❑ Other:		
Current Therapy? (Please include any procedures, medications, dosages, etc.)		

Your Expectations for this Patient?

❑ Emergency/Critical Care ❑ Physical/Hydro Therapy ❑ Diagnostic Imaging

❑ Surgical Consultation/Surgery ❑ After-Hours/Overnight Monitoring (for stable patients only)

❑ Other: