

VCA Metzger Animal Hospital

1044 Benner Pike, State College, PA 16801

P 814-237-5333 **F** 814-237-1712 **E** 1301-metzgerreceptionist@vca.com

Patient Referral Form

Today's Date: _____ **Referring Doctor:** _____

Referring Hospital: _____

Hospital Phone Number: _____ **Hospital Email:** _____

Owner Name: _____

Secondary Owner Name: _____

Main Contact Number: _____

Secondary Contact Number: _____

Owner Address: _____

Owner's Email: _____

Pet Name: _____

Species: Canine Feline Other: _____ Sex: Male Female

Spayed/Neutered: Yes No

Breed: _____ Color: _____ Age: _____

Rabies Vaccine Status/ Expiration Date: _____

Patient Alerts: _____

Referral Service: (please check all that apply)

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> *Emergency/Critical Care | <input type="checkbox"/> *Hospitalization | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Cardiology |
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Oncology | <input type="checkbox"/> Surgery | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Imaging/CT/X-Ray | <input type="checkbox"/> Other: _____ | | |

*For Hospitalization and Emergency transfers please call us so we may discuss the case with you.

Chief Complaint: _____

Brief History/Current Treatments (please include known drug allergies and chronic medical conditions):

Medical Records and Lab Work:	<input type="checkbox"/> Faxed
	<input type="checkbox"/> Emailed
	<input type="checkbox"/> Sent with Client
	<input type="checkbox"/> None

Diagnostic Imaging:	<input type="checkbox"/> Emailed
	<input type="checkbox"/> Sent with Client
	<input type="checkbox"/> None

Please send all relevant medical records, diagnostic results, and completed Referral Form to:

Email: 1301-metzgerreceptionist@vca.com **Fax:** 814-237-1712

