VCA ANIMAL SPECIALTY GROUP

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PATIENT REFERRAL FORM

DATE_____

REFERRING VETERINARIAN_____
HOSPITAL NAME_____
ADDRESS_____
E-MAIL ADDRESS_____
TELEPHONE_____FAX_____BEST TIME/DAY TO CONTACT YOU_____

REFERRAL REQUEST: As the referring veterinarian, my expectations for this cares are as follows:
(Please check one) _____Referral for the following procedure(s)_____

_____

_____

_____Overnight care and return in the morning _____Hospitalization for definitive care

IMPORTANT NOTE: In recognition of changes in patient condition, doctor's evaluation and client wishes, Animal Specialty Group reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgement dictates.

CLIENT'S NAME_____
ADDRESS_____
TELEPHONE_____PET'S NAME_____SPECIES_____
BREED_____AGE_____SEX_____WEIGHT_____

PRESENTING COMPLAINT_____

_____

HISTORY_____

_____

DIAGNOSTIC TESTS PERFORMED_____

_____

TREATMENT / MEDICATIONS____(time meds to be given time meds were last given)

_____

RESPONSE TO THERAPY _____

_____

ADDITIONAL COMMENTS_____

_____

Please ask your client to call us for an appointment, and send the following to us via fax, E-mail or with the pet owner:

_____Copies of all pertinent laboratory work
_____Radiographs
_____Ultrasound
_____Endoscopic prints or videotape
_____Other_____

THANK YOU FOR YOUR REFERRAL. We will stay in close communication with you about your patient's care.