PATIENT REFERRAL FORM

Appointment Date: _____ Time: _____

Primary Care DVM: _____ Referred to Doctor/Dept.: _____

Primary Care Hospital: _____

Address: _____

Phone: _____ Backline: _____

Fax: _____ Email: _____

Services Requested:

Complete Specialty Consult: _____

Contact Preference: _____

Specific Diagnostics: _____

Specific Treatment: _____

If available, please send the following with your client; patient information to include:

☐ Medical Notes/Records ☐ Imaging

☐ Lab Work Results ☐ Treatments, including last time administered

☐ X-Rays ☐ Other: _____

Name of Client/Agent: _____ Co-Owner: _____

Main Phone: _____ Alt. Phone #: _____

Email: _____ Other: _____

Address: _____

☐ Client has CareCredit ☐ Client has Pet Insurance

Patient Name: _____

Species: _____ Breed: _____

Age: _____ Color: _____

Sex: ☐ F ☐ SF ☐ M ☐ CM ☐ Unknown

Tentative Diagnosis/Chief Complaint: _____

History/Physical Findings: _____

Treatment (including medications and dosages): _____

Special Requests/Comments: _____