VCA Great Lakes Veterinary Specialists
4760 Richmond Road
Warrensville Heights, OH 44128
Phone: 216-831-6789
Fax: 216-831-4653

PATIENT REFERRAL FORM

Date: ________________________ Time: ________________________
Primary Care DVM: ________________________
Primary Care Hospital: ________________________
Address: ________________________
Phone: ________________________ Fax: ________________________
Email: ________________________

Referred To:

☐ Dentistry ☐ Emergency/Critical Care
☐ Internal Medicine ☐ Ophthalmology
☐ Other: ________________________

Client Information

First Name: ________________________ Last Name: ________________________
Primary Phone: ________________________ Alt. Phone: ________________________
Email: ________________________
Address: ________________________

☐ Client has CareCredit ☐ Client has Pet Insurance

Patient Information:

Name: ________________________ Nickname: ________________________
Species: ☐ Canine ☐ Feline Breed: ________________________
Age/Birthday:________________________ Color: ________________________
Sex: ☐ F ☐ FS ☐ M ☐ MN ☐ Unknown

Tentative Diagnosis/Chief Complaint: ________________________
____
____

History/Physical Findings: ________________________
____
____

Current Medications and Dosages:

1. ________________________ 5. ________________________
2. ________________________ 6. ________________________
3. ________________________ 7. ________________________
4. ________________________ 8.________________________

Patient Records: ☐ Emailed to au900@vca.com ☐ Faxed to 216.831.4653

*Please include medical notes, imaging and reports, lab work results, and treatments with last administration time

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