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
☐ Lab Work Results
☐ X-Rays
☐ Imaging
☐ Treatments, including last time administered
☐ 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: ______________________