VETERINARY EMERGENCY SERVICE — VETERINARY SPECIALTY CENTER

REFERRAL FORM

☐ ONCOLOGY ☐ SURGERY ☐ INTERNAL MEDICINE ☐ CARDIOLOGY ☐ ULTRASOUND

Referring Veterinarian:	Phone:
Referring Hospital:	Preferred Method of Contact:
Clinic Email:	Clinic Fax:

Did you send us: ☐ Pertinent Medical Records ☐ Bloodwork ☐ Histology/Cytology ☐ Radiographs

Did you tell the client: ☐ No food after 10pm ☐ Water is OK ☐ Bring all meds ☐ Bring Xrays/Medical Records

Client Information	**Pet Information**
Name:	Name:
Address:	Age:
State: Zip:	Breed/Color:
Home Phone:	Sex:
Cell Phone:	Weight:
Email (optional):	Pet Type: (circle) DOG CAT OTHER: (please list)

Presenting Complaint/History: IN PAIN? YES/NO
Physical Exam & Lab Findings:
Steroids, NSAIDs, Other Treatments (include dates and dosages):
Goals for Referral, Other Comments:

DVM Signature: _____