Referral Form

Referring Veterinarian _____ Referring Hospital _____

Phone _____ Fax _____ Email _____

Please select a service: ☐ Internal Medicine ☐ Surgery – Orthopedic/Soft tissue ☐ Critical Care ☐ MRI
☐ Emergency doctor on duty ☐ Anesthesia/Pain Medicine ☐ PT/Rehabilitation ☐ Other _____

Client Information:

Owners Name _____ Contact Phone Number _____

How would you like us to set up the referral? ☐ Call Owner ☐ Already Scheduled ☐ Direct care transfer (ER/ECC)

Pets name _____ Breed _____ DOB/Age _____ Sex _____

Medical Information: Please complete/answer all lines (or send a case summary)

Chief Complaint: _____

History: _____

Treatments/Current Therapy: _____

Radiographs: ◯ Performed & Will Email/Fax ◯ None Taken
Bloodwork: ◯ Performed & Will Email/Fax ◯ None Performed
Other Diagnostics: ◯ Performed & Will Email/Fax ◯ Results Pending ◯ None Sent
Rabies Vaccine Current? ◯ Yes Expiration Date: _____ ◯ No ◯ Unknown

Abnormal Test Results: _____

Comments/Special Requests: _____

Please email/fax all diagnostic test results with this referral form.
Radiographs can be emailed or sent on disc with the client.

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