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REFERRAL FORM

RDVM INFORMATION

Referring Doctor _____ Date _____
 Practice Name _____ Phone _____

CLIENT INFORMATION

Client's Name _____
 Client's Phone _____ Cell Phone _____

PATIENT INFORMATION

Pet's Name _____ Dog Cat FS MN F M
 Breed _____ Age _____
 Last Vaccination: Rabies _____ Other _____
 History, Physical Exam, Lab Results, etc: Written on back/attached Will send with client Faxed E-mailed
 Are there any images for this patient? No Yes Sent with client Mailed Digitally transmitted

CARE REQUESTED

- Please have a Critical Care Specialist evaluate the patient **TODAY!** (Available 8am – 8pm.)
- Please have Emergency Veterinarian evaluate and consult Specialist as needed, 24 hours daily.
 (Owners will NOT necessarily see/speak with the specialist.)
- Make an appointment for:**
 - Critical Care Follow-up
 - Cardiac Work-up
 - Surgery
 - Internal Medicine
 - Radiology
 - CT
 - Nephrology
 - Orthopedic
 - Ultrasound
 - Ultrasound
 - Neurology/
Neurosurgery
 - Oncology
 - Soft Tissue
 - Endoscopy
 - Other: _____

Working Diagnosis: _____

Expectations of Referral: _____

The following estimate has been provided to the client: \$ _____

COMMUNICATION REQUESTED

- Please fax visit summary of AVETS visit to referring doctor (default).
- Please e-mail visit summary of AVETS visit to: _____
- Please send visit summary of AVETS visit via United States Postal Service.
- IN ADDITION
 - Please call: After consult/evaluation After discharge Phone # on file Other _____
 - Other _____