



**Patient Referral Form**

**Referring Veterinarian Information**

Date: \_\_\_\_\_

Veterinarian: \_\_\_\_\_ Hospital: \_\_\_\_\_

**Client information**

Client: \_\_\_\_\_ Street Address: \_\_\_\_\_

Apartment Number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_

**Patient Information**

Pet's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: M F MN FS Rabies Vaccination History: \_\_\_\_\_

History: \_\_\_\_\_

Diagnostics performed: \_\_\_\_\_

Treatments performed: \_\_\_\_\_

Current medications: \_\_\_\_\_

Concurrent/long term medical conditions: \_\_\_\_\_

Additional Comments (additional space on back): \_\_\_\_\_

As the Primary Veterinarian, I would like to be (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Phoned after examination       | <input type="checkbox"/> Responsible for follow-up care |
| <input type="checkbox"/> Phoned after surgery/Procedure | <input type="checkbox"/> _____                          |

Referred to:  Surgery Service  Emergency Service – ETA: \_\_\_\_\_

*Please have your client contact LVSEH to schedule an appointment at their earliest convenience or, in the case of an Emergency Referral, please call or indicate an estimated time of arrival.*

***Please send us all recent lab results, radiographs and ultrasound images via e-mail, fax, mail, or with the pet owner. Thank you for allowing us to serve you and your clients.***

**PORT WASHINGTON**

