Internal Medicine Referral Form

EMAIL TO US
PRINT
RESET

Referring Veterinarian: _____ Date: _____

Referring Hospital: _____

Address: _____ Phone: ( ) _____ - _____

Fax: ( ) _____ - _____ E-mail: _____ Schedule Preference: Client to Call ☐ Please Call Client ☐

Please contact our office at (770) 486-0077 if you have an urgent referral. Thank you for your referral!

I would like to:

"Complete" Case Transfer: _____

Specific Diagnostics: _____

Specific Treatment: _____

Expectations for this case:

☐ Consultation
☐ Diagnosis
☐ Treatment Consultation
☐ Diagnosis Only
☐ Consultation Only

Please send the following with your client:

☐ All X-Rays
☐ Ultrasound Images

In addition to this form, please FAX or EMAIL:

☐ All Lab-work
☐ Treatments (Including Last Times Administered)
☐ Relevant Medical Records

Client(s) Name: _____

Phone (Day): ( ) _____ - _____ Phone (Night): ( ) _____ - _____ E-mail: _____

Patient's Name: _____ Species: _____ Breed: _____

Sex: Male ☐ Female ☐ Altered ☐ Age: _____ Temperament: _____

Tentative Diagnosis / Chief Complaint: _____

_____

_____

History / Physical Findings: _____

_____

_____

_____

Treatments (Including Medications and Dosages): _____

_____

_____

Special Requests / Comments: _____

_____

_____

vca animal hospitals

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