PATIENT REFERRAL

PATIENT REFERRED TO DR./SERVICE _____ ☐ ANNAPOLIS ☐ TOWSON

OWNER: NAME _____ (LAST / FIRST / MIDDLE) PHONE _____

ADDRESS _____ (STREET / CITY / STATE / ZIP)

PATIENT: NAME _____ SEX _____ AGE _____

SPECIES _____ BREED _____ COLOR _____

MEDICAL HISTORY:

VACCINATIONS

TYPE _____ DATE _____ TYPE _____ DATE _____

TYPE _____ DATE _____ TYPE _____ DATE _____

SURGERY (Tumors, Neuters, etc.) _____

_____

PRESENTED TO OUR HOSPITAL ON (DATE) _____

SYMPTOM OR PROBLEM _____

DURATION OF CONDITION _____

HAS CONDITION OCCURRED BEFORE? _____ WHEN? _____

ANY OTHER ANIMALS AFFECTED? _____

TENTATIVE DIAGNOSIS: _____

LAB RESULTS (DATES)**:** _____

_____

TREATMENT SCHEDULE (DATES)**:** _____

_____

_____

PRESENT CONDITION: _____

_____

REMARKS OR REQUESTS: _____

_____

Dear referral client: Your doctor is referring you to CVRC for further investigation into your pet's problem. In order to avoid duplication of work and expense please bring radiographs and a copy of any diagnostic tests which may have been performed. Since you will return to your own veterinarian after the resolution of this problem, we will send your doctor a letter detailing the events of your pet's visit so that your records may be kept up to date at your own hospital.

Please send _____ **additional referral forms.**

_____ **,D.V.M.**

ADDRESS _____

_____

PHONE _____