PATIENT REFERRAL

☐ ANNAPOLIS ☐ TOWSON ☐ COLUMBIA

PATIENT REFERRED TO DR./SERVICE ____________________

OWNER: NAME ____________________ PHONE ____________________
LAST FIRST MIDDLE

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.

____________________ **,D.V.M.**

ADDRESS ____________________

PHONE ____________________

Please send ____________ **additional referral forms.**