REFERRAL FORM

Avets
SPECIALTY & EMERGENCY TRAUMA CENTER

CARE REQUESTED

Make an appointment for:

- ☐ Critical Care & Emergency
- ☐ Surgery
- ☐ Outpatient Ultrasound
- ☐ Internal Medicine
- ☐ I-131
- ☐ Physical Rehabilitation

Neurology Coming Soon!

Working Diagnosis: _____

_____

Expectations for Referral: _____

_____

The following estimate was provided to the client: _____

REFERRING VETERINARIAN INFORMATION

Practice Name: _____

Referring Veterinarian: _____ Email: _____

Phone: _____ Fax: _____

CLIENT INFORMATION

Client Name(s): _____ Client Phone (Home): _____

Client Address: _____ Client Phone (Cell): _____

_____ Client Email: _____

PATIENT INFORMATION

Pet's Name: _____ ☐ Dog ☐ Cat ☐ Other ☐ FS ☐ MN ☐ F ☐ M

Breed: _____ Color: _____ Age: _____

Current Medications: _____

Is there imaging for this patient? _____

Does this patient interact well with others during visits? _____

COMMUNICATION REQUESTED

☐ Fax summary of Avets visit to referring doctor (default): _____

☐ Email summary of Avets visit to: _____

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