



**POINTS EAST**  
Veterinary Specialty Hospital

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## PATIENT REFERRAL FORM

Surgery       Emergency       Outpatient Abdominal Ultrasound       Outpatient Echocardiogram

### REFERRING VETERINARIAN INFORMATION

CURRENT DATE: \_\_\_\_\_

Referring Veterinarian Name: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_  
Hospital Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### CLIENT INFORMATION

Client Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Primary Email: \_\_\_\_\_  
Other Pertinent Phone Numbers: \_\_\_\_\_

### PATIENT/PET INFORMATION

Name: \_\_\_\_\_  
Species:  Dog/Canine     Cat/Feline    Gender:  Male     Female     Neutered/Spayed  
Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Known or Estimated Birth Date: \_\_\_\_\_  
Weight: \_\_\_\_\_ Has this pet previously been seen at PEVSH?  Yes  No

### MEDICAL HISTORY

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

Are there any special accommodations needed for this patient? (please describe) \_\_\_\_\_  
\_\_\_\_\_

Diagnostics pending?:  Yes     No \_\_\_\_\_

**Please fax or email the complete record & medical history to our hospital with submission of this form (include vaccine history, labwork, radiographs & any other pertinent information).**