POINTS EAST
Veterinary Specialty Hospital

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PATIENT REFERRAL FORM

☐ Emergency Critical Care / Emergency Surgery ☐ Specialty Surgery Service

☐ Outpatient CT ☐ 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).