



Circle City Veterinary Specialty & Emergency Hospital

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Residency Trained Emergency and Critical Care Medicine

EMERGENCY / CRITICAL CARE REFERRAL FORM

Attention to referring veterinarian: Please complete the following information regarding your patient and fax, mail, *or* send with your client for their first appointment.

Date _____

CLIENT:

Name _____

Address _____

City _____ State _____ Zip Code _____

PATIENT:

Name _____ Species _____

Breed _____ Sex _____ DOB _____

Vaccinations current: Yes ___ Date Given _____ No ___

Is this animal known to be aggressive? Yes ___ No ___

Referring Veterinarian _____ Hospital/Clinic Name _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____ Email _____

Reason for referral _____

History, clinical signs, laboratory findings _____

Tentative diagnosis _____

Patient's overall condition: Good ___ Fair ___ Poor ___ Lab work: Yes ___ No ___ Radiographs: Yes ___ No ___

Current Therapy _____

Medication _____ Date _____ Dose/Frequency _____ Response _____

Please send along with this form all previous diagnostic test results.

Comments _____

Please remember to include complete copies of your patient's medical records and lab results.

A summary of each visit will be forwarded to you and your client. Inquiries, comments, and suggestions are always welcome. Thank you for your referral.

12/23/2008