# PATIENT REFERRAL FORM

**Choose Form**

○ Patient Referral Form ○ Telemedicine Consult Form

**Client Name (First & Last)**

_____

**Client Address**

Street

_____

City _____ State _____ Zip _____

**Client Primary Phone**

_____

**Client Email**

_____

## Vet Hospital Information

**DVM**

_____

**Hospital Name**

_____

**Address**

Street

_____

City _____ State _____ Zip _____

**Phone**

_____

**Fax**

_____

**Email**

_____

## Pet Information

**Patient Name**

_____

**Breed**

_____

**Age**

_____

**Weight Kg**

_____

**Sex**

☐ Male Neutered ☐ Male Unaltered ☐ Female Spayed ☐ Female Unaltered

## Referral Information

**Consult requested with:**

_____

**Special Instructions:**

_____

**Chief Complaint for Referral**

_____
_____
_____
_____
_____
_____
_____

**Pertinent Medical History**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Current Medications**

_____
_____
_____
_____
_____
_____

**Completed Diagnostics:** Please be sure to include pertinent history and exam notes with all diagnostics

- ☐ CBC
- ☐ Chemistry Profile
- ☐ Urinalysis
- ☐ Thyroid Testing
- ☐ HW/Lyme/Ehrlichia/Anaplasma
- ☐ Other Labwork
- ☐ Blood Pressure
- ☐ ECG
- ☐ Radiographs
- ☐ Ultrasound Studies
- ☐ CT
- ☐ MRI
- ☐ Other _____

## Medical Records

**Please submit previous 12 months of medical records** Email info@uvsonline.com OR fax to 518.783.3199

***If you require a STAT consult, please call UVS at 518.783.3198 to speak directly with the appropriate specialist.***