PATIENT REFERRAL FORM

Choose Form

○ Patient Referral Form ○ Outpatient Ultrasound 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.