



**Patient Referral Form**

Date: \_\_\_\_\_

Have you called HVC about this referral?    Yes    No

**Referring Veterinarian Information:**

Veterinary Hospital \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Other Doctor's Involved: \_\_\_\_\_

**How would you prefer to be contacted on this case?**

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Client Information:**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Patient Information:**

Canine    Feline \_\_\_\_\_

Patient Name: \_\_\_\_\_

Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

**Requested Service:**

- |                       |                     |
|-----------------------|---------------------|
| Dentistry             | Radiology           |
| Diagnostic Procedures | Soft Tissue Surgery |
| Laser Surgery         | Other: _____        |
| Orthopedic Surgery    |                     |

**Patient Should Be Seen:**

within 24 hrs    within 24-72 hrs    At client's convenience

**X-Rays:**

- Yes
- No
- Client will bring

**Medical Records**

- Will be faxed
- Client will bring

**Lab Results:**

- Will be faxed
- Client will bring
- None     Results pending

**Expectations For This Case:**

Consult only. Please return to my office for diagnostic testing and treatment.

Please manage the diagnostic testing and treatment.

Reason For Referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Relevant History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous/Current Treatment(s) or Medication(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_