VETERINARY SPECIALTY CENTER

VETERINARY EMERGENCY SERVICE

☐ Internal Medicine ☐ Oncology ☐ Surgery ☐ Ultrasound

Referred by Dr:	Referring Hospital:
Address:	
Phone: ( )	Fax: ( )
Email:	Preferred method of updates: ☐Phone ☐Fax ☐Email
In addition to a report, would you like to be updated: ☐ after every recheck ☐ for significant findings only	
For in-patients, would you like updates: ☐daily ☐ for significant changes and upon discharge only	

Did you fax: ☐Pertinent Med Recs ☐ Bloodwork ☐Histo/cytol ☐ Email Rads ☐ Send Rads with client

Did you tell client: ☐ No food after 10pm ☐ H20 is OK ☐Bring Rads ☐Bring all meds

Name of Client:	
Address of Client	
	Home Phone: ( )
Cell Phone: ( )	Work Phone: ( )

Name of Patient:		Species:
DOB:	Color:	Breed:
Sex: ☐F ☐SF ☐M ☐MN ☐Unknown		Demeanor:

Tentative Diagnosis / Chief Complaint:

History/ Physical Findings:

In pain? Yes / No

Lab findings (*attach copy of results*)

Most Recent Vaccinations (*date and type*):

Steroids, NSAIDs, other treatments (Include dates and dosages):

Goals for referral, other comments:

Veterinarian's Signature:

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