Affiliated Emergency Veterinary Service

Patient Referral Form

REFERRING VETERINARIAN _____

HOSPITAL _____

PHONE _____ **DATE** _____

PATIENT'S NAME _____ Breed _____ Age _____

Client's name _____ Phone number _____

Reason for referral: _____

PATIENT INFORMATION (Please include pertinent history, diagnostic tests results and treatments administered and/or send relevant medical documents. Use the back of this form as needed.)

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PLEASE CHECK ONE:

❒ Patient care protocol to be determined by an AEVS veterinarian

❒ Recommended patient care protocol:

_____

_____

_____

Would you like to be notified if your patient's condition worsens?

❒ Yes Phone _____ ❒ No

IF MY PATIENT REQUIRES FURTHER CARE WHEN I OPEN (select one):

❒ Keep my patient at your clinic ❒ Refer my patient back to me ❒ Refer to a specialist

COMMENTS:

_____

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Please fax this form and all relevant medical documents to:

Eden Prairie (952-829-4089) • Golden Valley (763-529-1667) • Coon Rapids (763-754-5731)

Blaine (763-754-6002) • St. Cloud (320-258-3482) • Rochester (507-424-3980) • Duluth (218-302-8004)

Radiographs/medical records can also be emailed to doctor@aevs.com. Alternatively, please send this information with your client.