REFERRAL FORM

CARE REQUESTED

Make an appointment for:

- ☐ Critical Care & Emergency
- ☐ Internal Medicine
- ☐ Outpatient Ultrasound
- ☐ Avian & Exotics
- ☐ Neurology
- ☐ Surgery
- ☐ I-131
- ☐ Oncology

Working Diagnosis: ______________________________

____

Expectations for Referral: ______________________________

____

The following estimate was provided to the client: ______________________________

REFERRING VETERINARY INFORMATION

Practice Name: ______________________________

Referring Veterinarian: ______________ Email: ______________

Phone: ______________ Fax: ______________

CLIENT INFORMATION

Client Name: ______________ Client Phone (Home): ______________

Client Address: ______________ Client Phone (Cell): ______________

______________ Client Email: ______________

PATIENT INFORMATION

Pet's Name: ______________ ☐ Species: ______________ ☐ FS ☐ MN ☐ F ☐ M

Breed: ______________ Color: ______________ Age: ______________

Current Medications: ______________________________

Is there imaging for this patient? ______________________________

Does this patient interact well with others during visits? ______________________________

COMMUNICATION REQUESTED

☐ Fax summary of Avets visit to referring doctor (default): ______________________________

☐ Email summary of Avets visit to: ______________________________

2674 Monroeville Blvd., Monroeville, PA 15146 I Phone: 412.373.4200 I Fax: 412.373.4250

Avets.com I Referrals@Avets.com