

## Referral Record Sheet

Referring hospital: \_\_\_\_\_ Referring doctor: \_\_\_\_\_

After hour phone number(s) at which doctor can be contacted: \_\_\_\_\_

Client name: \_\_\_\_\_ Client phone number: \_\_\_\_\_

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

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_

Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Spay/Neutered? \_\_\_\_\_

Presenting Complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Exam: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Prognosis: \_\_\_\_\_

Treatment(s) at referring hospital: (Please send/fax hospital records and all lab results)

Medication	Amount	Route	Time last dose given	Frequency

Instructions and treatment plan for VES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_