METROPOLITAN VETERINARY ASSOCIATES

METROPOLITAN VETERINARY URGENT CARE & SPECIALTY

# REFERRAL FORM

REFERRING VETERINARIAN: _____

HOSPITAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CLIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PATIENT NAME: _____

SPECIES: _____ BREED: _____

COLOR: _____ DOB: _____ SEX: _____ WEIGHT: _____

## DEPARTMENT

- ☐ ANESTHESIA
- ☐ BEHAVIOR
- ☐ CARDIOLOGY
- ☐ DENTISTRY
- ☐ DERMATOLOGY
- ☐ EMERGENCY AND CRITICAL CARE
- ☐ INTERNAL MEDICINE
- ☐ MINIMALLY INVASIVE SURGERY
- ☐ NEUROLOGY
- ☐ ONCOLOGY
- ☐ OPHTHALMOLOGY
- ☐ RADIOLOGY
- ☐ SURGERY
- ☐ OTHER: _____

REQUESTED DOCTOR (IF ANY): _____

## REFERRAL DETAILS

CHIEF COMPLAINT: _____

HISTORY: _____

DIAGNOSTICS: _____

TREATMENTS/MEDICATIONS: _____

ENCLOSURES: ☐ LAB ☐ REPORTS ☐ RADIOGRAPHS ☐ OTHER

Please email this form along with diagnostics if applicable to info@metro-vet.com **OR** fax to 610-666-1199; If this is an emergency, please contact us at 610-666-1050 to speak directly with one of our emergency clinicians so we can be prepared to provide the patient with the appropriate care upon their arrival.