Arkansas Veterinary Emergency & Specialists

11619 Pleasant Ridge Road Little Rock, AR 72212
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REFERRAL INFORMATION FORM

Date of Referral:_____

To: ☐ Int. Medicine ☐ Dermatology ☐ Dentistry ☐ Ophthalmology

Referring Veterinarian Data:

Dr. Name_____ Hospital Name_____

Phone_____ Fax_____ Email_____

Additional Letter / information sent with client? ☐ YES ☐ NO

Other information provided: ☐ Medical Records ☐ Radiographs ☐ Images ☐ Synopsis Letter ☐ Other_____

Client Information: ****(Please have client call us to set up an appointment)****

Owner's Name_____ Owner's Phone_____

Patient Data:

Name_____ Species_____ Gender: ☐ Male ☐ Female ☐ Neutered/Spayed

Breed_____ Date of Birth_____ Color_____

Vaccinations: (Date of Last) Distemper_____ FeLV_____ Rabies_____ HWT_____

Significant Past Medical History / Problems:

_____

_____

_____

_____

Current Problem: (Please indicate/describe chief complaint / onset / progression / treatments)

_____

_____

_____

_____

Tentative Diagnosis Given to Client:_____

Medications: (Please list all current medications and dosages)

_____

_____

Referral Report: A referral report will be faxed to you shortly after your client's visit. If you have another preference, please let us know. Email:_____

Additional Comments:_____

WE APPRECIATE YOUR REFERRAL!