petcrossing
state of the heart medical arts

REFERRAL INTAKE FORM

Referral Information:

Referring DVM _____
Clinic/Hospital _____
Address _____
City, State, Zip _____
Phone _____
Fax _____
Email (*for results*) _____

Client Information:

Name _____
Address _____
City, State, Zip _____
Primary Phone _____
Other Phone _____
Email _____

Services Requested:

Please indicate which diagnostics have been completed, labs/images should be sent via email, fax or with owner.

☐CBC ☐Chemistry
☐Urinalysis ☐Radiographs

Is the rDVM requesting sampling during CT? (if possible)
☐Yes ☐No

(If yes, we will run PT/PTT day of procedure).
(Cytology will be completed in house or sent to Idexx).
(Reports will be returned to rDVM to report to the owner).

☐Other:
_____

Visit Timeframe:

☐Patient should be seen within 24-72 hours
☐Patient should be seen within 7 days
☐Patient scheduling is non-urgent

Patient Information:

Name: _____
Species: _____
Breed: _____
Color: _____
DOB: _____
Sex: _____

Primary Reason for Referral:

Owner/Referring DVM Expectations for this Case:
(please specify rDVM's request: report only or images with report when possible)

Medical history related to referral:

Medication history:
(please provide dates, doses, and response):

Are there any specific instructions that can help us meet the unique needs of this client or patient?