REFERRAL RECORD

emergencyvetservices.net

Date: _____

Referring Hospital/Doctor:_____Phone:_____

Prefer to be contacted by: ☐ Phone: _____ ☐ email: _____

Do you want to be called about this patient? ☐ yes ☐ no If not, the doctor on duty will treat as s/he feels appropriate.

Owner name: _____Phone:_____

Address: _____

Patient Name:_____Breed:_____Age:____Weight:____

Presenting Complaint: _____

_____

Physical Exam: _____

_____

_____

Laboratory Test/Special Procedures: _____

_____

_____

Medications Given at Referring Hospital:

Medication Given:	How Much?	Time Given:

Recommendations for Treatment Plan: _____

_____

_____

_____

_____

Please inform clients of the following:

1. At EVS, they will be given an itemized estimate and asked to leave a deposit of approximately ¾ of estimate.
2. Remaining fees are due and payable when the patient leaves EVS. We accept cash, approved check, all major credit cards, and Care Credit.

4902 Frontage Road, Roanoke, VA 24019 (540) 563-8575 Fax (540) 563-9959

SUBMIT FORM

We appreciate the continued referral of your patients to us!