



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.

Please attach any related radiographs or lab work and email your completed form to evsroanoke@gmail.com.

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

We appreciate the continued referral of your patients to us!