Patient Referral Transfer Form

Date: ______________________________
Referring D.V.M.: ______________________
Referring Hospital: _____________________
Hospital Phone: _______________________
DVM Home Phone: _____________________
DVM Alt. Phone: ______________________
Patient Name: __________________
Weight: _________________
Breed: _____________________________

E.T.A. to ER : _________________________
# of Pages in Record: _____________
Owner: ____________________________
Owner Phone: __________________
Address: ___________________________
City, Zip: ___________________________
Age: _______ Sex: M F N/S (circle one)
Color: _______ Current Vax? Y/N

Items accompanying the patient:

Records Radiographs ECG Fluids Medications Carrier Other _____________________

Tentative diagnosis: ____

TREATMENT PERFORMED AT REFERRING HOSPITAL

Laboratory Specimen: Blood Urine Tissue

Lab: IDEXX Antech Other Lab Account Number _______

TREATMENT	TYPE	AMOUNT	TIME(s) GIVEN
Antibiotic			
Antibiotic			
Anti-inflammatory			
Catheter Yes No			
Fluids			
Other Medications			
Surgery			
Other Treatments			

SPECIFIC INSTRUCTIONS TO CCPEC:

Observation Only
Treat as Staff Clinician Deems Necessary
Treatment as Follows:

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Should the patient's condition worsen or expire we are to:

Call the referring veterinarian Call the owner directly Contact Both

Signed: ______________________________ Date: ______________