



4706 New Horizons Blvd., Appleton, WI 54914 (920) 993-9193

HOSPITAL REFERRAL FORM

SERVICE: ER SX Med Optho Derm
 Other _____

PURPOSE: Appt Review

Date _____ Time _____

Doctor _____ Hospital _____ Phone _____

Owner _____ Pet _____ Phone _____

Species _____ Breed _____ Age _____ Sex: M F MC FS

Items accompanying patient: Radiographs Records ECG Fluids Meds Other _____

Significant diagnostics completed:

Diagnostics initiated, results pending:

Therapeutics initiated:

Tentative diagnosis:

INSTRUCTIONS FOR THE FOX VALLEY ANIMAL REFERRAL CENTER

Preferred course of action:

- Observation and monitor only
- Treat as emergency clinic doctors and client deem necessary
- Treat as follows:

IMPORTANT NOTE: *In recognition of changes in patient condition, doctor's evaluation, and client wishes, the Fox Valley Animal Referral Center reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates.*

Referring Doctor _____ Clinic phone _____ Home phone _____

Call me if _____