

**REFERRAL REPORT - PLEASE PRINT CLEARLY**

Date: \_\_\_\_\_

**REFERRING VETERINARIAN INFORMATION:**

Referring Veterinarian \_\_\_\_\_

Phone: \_\_\_\_\_

Clinic: \_\_\_\_\_

Preferred Method of Contact:  Phone  Email  Fax

Are you willing to receive emailed records?  Yes  No



**URGENT referral for Emergency Care**

Please check if this is an emergency referral

**7 days a week, 6 AM – 10 PM**

Please also call Pacific Northwest Pet ER & Specialty Center about this case for immediate attention.

**SPECIALTY SERVICE REQUESTED:**

Critical Care  Surgery  Internal Medicine  Oncology  Cardiology

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_

M  M/N  F  F/S Age: \_\_\_\_\_

Canine  Feline

Breed: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

**PATIENT HISTORY & REASON FOR REFERRAL:**

**MEDICATIONS ADMINISTERED, INCLUDING DOSE, ROUTE, AND TIME:**

**DIAGNOSTICS PERFORMED (ATTACH RESULTS OR STATE IF PENDING)**

Laboratory Reports  Radiographs  Other: \_\_\_\_\_