Arkansas Veterinary Emergency & Specialists

11619 Pleasant Ridge Road Little Rock, AR 72212
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REFERRAL INFORMATION FORM

Date of Referral:_____________

To: ☐ Int. Medicine ☐ Dermatology ☐ Dentistry ☐ Ophthalmology

Referring Veterinarian Data:

Dr. Name_________________________________ Hospital Name____

Phone___________________________ Fax_________________________ Email_____________________________________

Additional Letter / information sent with client? ☐ YES ☐ NO

Other information provided: ☐ Medical Records ☐ Radiographs ☐ Images ☐ Synopsis Letter ☐ Other____________

Client Information: ****(**Please have client call us to set up an appointment**)****

Owner's Name____ Owner's Phone__________________________________

Patient Data:

Name_____________________________ Species_______________ Gender: ☐ Male ☐ Female ☐ Neutered/Spayed

Breed__________________________________ Date of Birth_______________________ Color_________________________

Vaccinations: (Date of Last) Distemper______________ FeLV______________ Rabies______________ HWT____________

Significant Past Medical History / Problems:

____

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Current Problem: (Please indicate/describe chief complaint / onset / progression / treatments)

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Tentative Diagnosis Given to Client:____

Medications: (Please list all current medications and dosages)

____

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Referral Report: A referral report will be faxed to you shortly after your client's visit. If you have another preference, please let us know. Email:____

Additional Comments:____

WE APPRECIATE YOUR REFERRAL!