# Patient Referral Form

P: 206-204-3366

F: 206-204-3858

**Regular Referral for Internal Medicine**

| Client & Patient Information | | Referring Doctor Information | |
|---|---|---|---|
| Client Name | | Primary DVM | |
| Patient Name | | Hospital | |
| Client Phone | | Address | |
| Lab Used | | DVM Phone | |
| Lab Acct. # | | DVM Fax | |

Prognosis given client: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Grave

## Brief Case History

*Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.*

## Referral Request

As the referring veterinarian my expectations for this case are as follows (check one)

☐ 1. Referral for the following procedure(s):

______________________________________

☐ 2. Hospitalization for definitive care

☐ 3. Overnight care and return in the morning

***Important note:*** In recognition of changes in patient condition, doctor's evaluation and client wishes, AMCS reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates.

**THANK YOU FOR YOUR REFERRAL.**