

PATIENT REFERRAL FORM

**** PLEASE COMPLETE THIS FORM AND RETURN VIA FAX 719-434-9502
OR EMAIL referrals@powerspetemergency.com ****

REASON FOR REFERRAL:

- Cardiology
 Internal Medicine
 Neurology
 Radioiodine (I-131)
 Rehabilitation
 Surgery
 Diagnostic Imaging:
 Ultrasound
 CT scan
 MRI

Referring Veterinarian

Referring DVM: _____

Hospital Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____

Preferred Method of Contact: Phone / Fax / E-Mail

Patient Information

Owner's Name: _____

Pet's Name: _____

Species: _____ Breed: _____

Age: _____ Sex: M / NM / F / SF

Diagnosis: _____

Previous Medical Conditions: _____

Reason For Referral:

Brief Medical History:

Latest Treatments / Medications Administered:

Comments:

****PLEASE SEND ALL PERTINENT X-RAY, LAB WORK, AND MEDICAL RECORDS TO
719-434-9502 -OR- referrals@powerspetemergency.com ****



5886 Tutt Blvd | Colorado Springs, CO 80923
Phone (719) 473-0482 | Fax (719) 434-9502

Specialty and Referral Services

REQUEST FOR PATIENT RECORDS

TO:
Fax:
Phone:
Request Submitted:

Patient:
Client:

****Please send records ASAP or on the same date as this request is received.****

Powers Pet Emergency & Specialty is requesting the following information regarding the above-mentioned patient:

- Complete the attached Referral Form
- Doctor's notes and pertinent patient history for the last 6 months
- Lab tests and results, completed and pending
 All labs included Pending: _____ None
- Imaging (Radiographs, Ultrasounds, CT, MRI)
 Hard copy or disc with client E-Mail to referrals@powerspetemergency.com None

Special Requests / Comments: _____

Email: referrals@powerspetemergency.com (preferred)
Fax: (719) 434-9502

**Thank you for getting records to us quickly to ensure the best possible care for the patient.
Please let us know if you have any questions.
(719) 473-0482**