2281 W. Eau Gallie Blvd.,
Melbourne, FL, 32935
P: (321) 725-5365
F: (321) 242-5755
aecc@centralfloridaanimaler.com

VETERINARIAN REFERRAL FORM

If you are referring your patient for an appointment with one of our specialty services, please complete the Referral Form below. If you need to transfer an emergency case to the ER, do not use this form - please call us at (321)725-5365.

You will receive a copy of the patient's medical report and/or a doctor's letter so that your patient's care is seamless. We look forward to partnering with you, and welcome your telephone calls, faxes, and e-mails. If you would like to consult with one of our doctors on a particular case or have questions regarding a patient that is currently undergoing treatment at our facility, please don't hesitate to contact us.

REFERRAL DETAILS

Specialty Service for Referral (circle): Surgery

Is this an urgent referral (circle)? YES NO

Appointment Scheduling Preference: Call client directly Client will call us

REFERRING VETERINARIAN INFORMATION

Referring Practice Name: _____

Referring DVM: _____

Phone: _____ Fax: _____

Email: _____

Address:_____

City: _____ State: _____

CLIENT INFORMATION

Client Name: _____

Address:_____

City: _____ State: _____

Client Phone: _____ Client Email: _____

PATIENT INFORMATION

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Patient Name: _____

Patient Age/DOB: _____ Patient Species: _____

Patient Breed: _____ Patient Color/Marking:_____

Patient Weight: _____

Patient Sex-Status: Male-Neutered Male-Unaltered Female-Spayed Female-Unaltered

Rabies Vaccine Current (circle)?: YES NO

Rabies Vaccine Expiration Date: _____

Reason for Referral:_____
_____
_____
_____
_____

History Relating to Referral (duration, progression, treatments given, any response to treatments, owner's goals with referral): _____
_____
_____
_____
_____

Current Medications (list all, including dose and frequency):_____
_____
_____
_____
_____
_____

Relevant Medical History/Master Problem List for this Patient:_____
_____
_____
_____
_____

Are there any specific instructions to help us meet the needs of this patient (e.g. muzzle, go slow, food motivated, needs pre-visit sedation)? _____
_____
_____
_____
_____
_____
_____

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PATIENT FILES

Medical Records (circle): Will be Faxed Will be Emailed

Lab Results (circle): Will be Faxed Will be Emailed None to Send

Diagnostic Images (circle): Will be Faxed Will be Emailed None to Send

NOTE: MEDICAL RECORDS ARE REQUIRED TO PROCESS REFERRALS

PLEASE EMAIL MEDICAL RECORDS, ALONG WITH RELEVANT LAB RESULTS AND DIAGNOSTIC IMAGES TO AECC@CENTRALFLORIDAANIMALER.COM OR FAX TO (321) 242-5755