

Veterinarian Referral Form

"If your patient is in need of immediate service, please call our hospital at 512-343-2837 to speak with our Emergency/Critical Care Team. Please mark the service needed for the patient below: Surgery and Orthopedics Neurology and Neurosurgery Internal Medicine and Interventional Radiology Oncology Critical Care (Please call directly to refer) Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint Clinic Information Referring DVM: Fax: Email:	DATE:
Surgery and OrthopedicsNeurology and NeurosurgeryInternal Medicine and Interventional RadiologyOncologyCritical Care (Please call directly to refer)Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint Clinic Information Referring DVM: Clinic Name:	
Neurology and NeurosurgeryInternal Medicine and Interventional RadiologyOncologyCritical Care (Please call directly to refer)Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint	Please mark the service needed for the patient below:
Internal Medicine and Interventional RadiologyOncologyCritical Care (Please call directly to refer)Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint	Surgery and Orthopedics
OncologyCritical Care (Please call directly to refer)Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint	Neurology and Neurosurgery
Critical Care (Please call directly to refer) Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint	Internal Medicine and Interventional Radiology
Anesthesiology (Requires referral to our emergency or specialty departments) Specified Doctor (optional) Reason for Referral/Primary Complaint	Oncology
Specified Doctor (optional) Reason for Referral/Primary Complaint	Critical Care (Please call directly to refer)
Reason for Referral/Primary Complaint Clinic Information Referring DVM: Clinic Name: Phone: Fax:	Anesthesiology (Requires referral to our emergency or specialty departments)
Clinic Information Referring DVM: Clinic Name: Phone: Fax:	Specified Doctor (optional)
Clinic Information Referring DVM: Clinic Name: Phone: Fax:	
Clinic Information Referring DVM: Clinic Name: Phone: Fax:	,
Referring DVM: Clinic Name: Phone: Fax:	
Phone: Fax:	<u>Clinic Information</u>
	Referring DVM: Clinic Name:
Email:	Phone: Fax:
	Email:

What is your preferred contact method?

Client/Patient Information

Client Name:		Co-owner N	owner Name:		
Phone :					
Email:				· · · · · · · · · · · · · · · · · · ·	
Patient Name:		Breed:			
Sex: MaleNeutered Spayed		Age/DOB:	Weight:	lbs/kg	
Is the patient's rabies vaccine curre	ent? Y	N			
Is the patient infectious?	Υ	N If yes	s, please explain:		
Additional Patient Information					
		Patient File	<u>s</u>		
Medical Records (please circle)	Will Email	Will Fax	Client will bring		
Lab Results (please circle)	Will Email	Will Fax	Client will bring	None Performed	
Diagnostic Images (please circle)	Will Email	Will Fax	Client will bring	None Performed	
lf you have any questions or concerns ।	egarding your refe	rral, please call our h	nospital at 512-343-2837	so we can assist you further.	
If you would like to set up an online vet	erinarian referral p	ortal login, please en	nail portal@austinvets.co	om.	
For any technical issues with your refer	ral portal, please	email portal@austin	vets.com.		

Thank you for trusting AVES with your patient's care and for your continued collaboration!