WHEAT RIDGE
ANIMAL HOSPITAL

Referral Form

TEL: 303-424-3325 | 10140 W 44th Ave. Wheat Ridge, CO 80033

PLEASE FAX RECORDS AND THIS COMPLETED FORM TO: 303-420-8360

CLIENT AND PATIENT INFORMATION: *(please fill out on behalf of the client)*

Client Name: _____ **Preferred Phone:** _____
◯ Home ◯ Cell ◯ Work

Patient Name: _____

Date of Birth: _____

Breed: _____ **Species :** ◯ Canine ◯ Feline **Sex:** ◯ Neutered Male ◯ Intact Male ◯ Spayed Female ◯ Intact Female

MEDICAL INFORMATION

Note: Please forward all pertinent medical record information including results of laboratory tests by fax or email. This allows our staff to review details of the case prior to the appointment and provide optimal patient care and client service. Radiographs and additional copies of the record may be sent with the client on the day of the appointment.

Service Referred to: _____

Diagnosis/Immediate Problem: _____

History: *(signs, onset, progression)* _____

Do you want us to call the client to schedule? ◯ Yes ◯ No

Type of Appointment? ◯ Urgent ◯ Follow up Consult ◯ New Consult

Were X-rays Taken? ◯ Yes ◯ No

Vaccination History: _____

Current Diet: _____ **Weight:** _____ **Body Condition:** ____ **/ 9**
(if prescribed)

Diagnostics Performed: *(please attach test results)* _____

Current Medications: *(include dosage, duration, response)* _____

Other Treatments/Prior Medications? *(Please list)*: _____

Case Summary/Comments: _____

REFERRING VETERINARIAN INFORMATION:

Referring Veterinarian: _____

Referring Veterinary Hospital: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Signature: _____ **Date:** _____