ULTRASOUND PATIENT REFERRAL FORM

Phone #: 613-383-8381 E-mail: eaglesonvc@gmail.com

Eagleson Veterinary Clinic

REFERRING HOSPITAL INFORMATION:

REFERRING HOSPITAL NAME: _____ DATE: _____
HOSPITAL E-MAIL: _____ HOSPITAL PHONE: _____
REFERRING DVM: _____

PREFERRED METHOD OF COMMUNICATION:

☐ PHONE ☐ E-MAIL

WHEN SHOULD PATIENT BE SEEN BY US?:

☐ EMERGENCY – PLEASE CALL ☐ URGENTLY (WITHIN A WEEK)

☐ NEXT AVAILABLE APPOINTMENT ☐ PROVIDE ESTIMATE ONLY

DOCUMENTS INCLUDED WITH REFERRAL:

☐ MEDICAL RECORD ☐ RADIOGRAPHS ☐ LAB RESULTS

REASON FOR REFERRAL/PRESENTING COMPLAINT:

_____
_____
_____
_____

CLIENT INFORMATION:

NAME: _____ E-MAIL: _____
ADDRESS: _____
PHONE (h): _____ (c): _____

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PATIENT INFORMATION

PET NAME: _____ DATE OF BIRTH: _____ SPECIES/BREED: _____

GENDER: ☐ M ☐ M (n) ☐ F ☐ F (s)

RELEVANT PATIENT HISTORY & CURRENT MEDICATIONS:

PLEASE PROVIDE A RELVANT AND DETAILED CASE SUMMARY PERTAINING TO THIS REFFERAL.

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I CONSENT TO THE USE AND STORAGE OF MY INFORMATION BY EAGLESON VETERINARY CLINIC FOR THE PURPOSES OF EVALUATION AND MEDICAL TREATMENT OF THE REFERRED PATIENT LISTED ABOVE.

_____

SIGNATURE OF REFERRING DVM