

Patient Referral Form

P: 360-694-3007

F: 360-735-7420



Emergency Services

Critical Care

Internal Medicine

Surgery

Client & Patient Information		Referring Doctor Information	
Client Name		Primary DVM	
Patient Name		Hospital	
Client Phone		Address	
Lab Used		DVM Phone	
Lab Acct. #		DVM Fax	

Brief Case History

Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.

Referral Request

As the referring veterinarian my expectations for this case are as follows (check one)

- 1. Referral for the following procedure(s):

- 2. Overnight care and return in the morning
- 3. Hospitalization for definitive care

Important note: In recognition of changes in patient condition, doctor's evaluation and client wishes, CRVS reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates

THANK YOU FOR YOUR REFERRAL.