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Toll-Free: 1.877.773.7079
info@centralislandvetemerg.com
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Patient Referral Form

REFERRING VETERINARY INFORMATION

Dr. ____ Hospital Name: ____

Phone Number: _________________ Fax Number: _________________ Email: _______________________________________

CLIENT INFORMATION

Name: ____

Address: ____

Contact Number: ______________________ Email: ____

PATIENT INFORMATION

Name: _____________________________ Breed: _________________________ D.O.B: ______________________________

Sex: ☐ M ☐ F Neutered/Spayed: ☐ Yes ☐ No Colour: __________________ Weight: ________________

Patient is: ☐ CRITICAL ☐ STABLE

Referral Reason: ☐ No Appointments Available ☐ We Are Closed/Closing ☐ Patient Needs Overnight Monitoring

Case Summary: (Please attach any information such as medical records, lab results, or additional sheets)

Lab Samples: ☐ Coming with Client ☐ Not Collected Yet ☐ Complete and Attached

X-Rays: ☐ Coming with Client ☐ Not Performed Yet ☐ Emailed to info@centralislandvetemerg.com

Checklist:

☐ Medical records have been faxed
☐ An estimate has been prepared for the client by CIVEH, they have signed and it has been faxed back
☐ CIVEH has been called and notified of estimated time of arrival
☐ Client has been informed that ***if the animal is stable*** and CIVEH has another critical patient, there may be a wait