CENTRAL ISLAND
Veterinary Emergency Hospital

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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