Patient Referral Form

Date:

Referring Doctor: _____

Referring Clinic/Hospital: _____

Phone: _____ Fax: _____

Email: _____

Preferred contact method: ☐ Phone ☐ Fax ☐ Email ☐ Mail

Client name: _____

Home Phone: _____ Work phone: _____ Cell phone: _____

Patient Name: _____ Breed: _____ Species: ☐ Canine ☐ Feline ☐ Other

Sex: ☐ Female ☐ Male ☐ Spayed/Neutered Age: _____ Birthdate: _____

Referred to: ☐ Surgery ☐ Internal Medicine ☐ Emergency ☐ Pain Management ☐ Other

Chief Complaint/ Tentative Diagnosis:

_____

_____

_____

_____

_____

History/ Physical Findings:

_____

_____

_____

_____

Laboratory Data: (Please attach copies of results)

Treatments/Medications: (Please attach copies of results)

Radiographs sent with client: (films/CDs will be returned) ☐ Yes ☐ No

Note to Clients: Please bring this form and a list of all medications to your pet's initial exam. At the time you make your appointment, please ask if you need to withhold food or medications before your appointment. Fees are payable in full at the time of services rendered. Payment may be made by cash, MasterCard, Visa, American Express or Discover.

Keauhou Veterinary Hospital
Dr. Jacob Head
78-6728 Walua Rd., Kailua-Kona, HI 96740 Phone: 808-322-2988 Fax: 808-322-2303
Website: www.keauhouvet.com Email: info@keauhouvet.com