



# Patient Referral Form

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**OPEN 24/7/365**

## Referring Veterinarian

Referring Veterinarian Name \_\_\_\_\_ Phone \_\_\_\_\_

Practice Name \_\_\_\_\_ Fax \_\_\_\_\_

Preferred Method Of Communication:  Fax  Phone  Email (Address) \_\_\_\_\_

## Referred Patient and Client

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Patient Name \_\_\_\_\_

Species:  Canine  Feline Sex:  Male  Female  Altered Breed: \_\_\_\_\_ Age: \_\_\_\_\_

Current Food/Diet: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Vaccination Status:**  All Are Current  Current On Rabies Only  All Are Overdue  Unknown

**Reason For Referral** \_\_\_\_\_

**Immediate History** \_\_\_\_\_

**Tentative Diagnosis** \_\_\_\_\_

## Current Medications

Medication	Dosage and Route Of Administration	Last Given
1.		
2.		
3.		
4.		
5.		
6.		
7.		

**Other Information/Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Transfer Patient Back To Regular Veterinarian:**  Yes (Time Desired: \_\_\_\_\_)  No