Flower Mound Emergency Pet Clinic

REFERRAL

Please complete and fax this form for every referral to: 469.464.2971

DATE	TIME
REFERRING CLINIC	

Would you like us to contact you if the patient's condition changes?
☐ **YES** ☐ **NO** If so, please provide:

CONTACT	PHONE	HOURS

Client Name _____ Patient Name _____

Species _____ Breed _____

Date of Birth _____ Color _____ Weight _____ ☐Male ☐Female ☐Neutered

Presenting Complaint and History:

Initial T/P/R/Pressures	T (f/c)	Pulse	Resp	Pressure	Time
Last T/P/R/Pressure	T (f/c)	Pulse	Resp	Pressure	Time

Diagnostics Performed: ☐Bloodwork ☐Rads ☐Ultrasound ☐Fecal ☐Urinalysis ☐Heartworm Occult ☐Feline Viral

Other, please list _____

Outside labwork pending, please list _____ Lab Submitted to _____

PLEASE FAX COPY OF ALL LABWORK, RECORDS AND SEND ANY RADIOGRAPHS.

Surgical Procedures Performed _____

Diagnosis/Differential:

Medications Administered (Time/Medication/Concentration/Amount/Route)

1.	4.	7.
2.	5.	8.
3.	6.	9.

☐ IV Cath (Size/Placement/Time of Placement) _____

☐ Fluids administered (Type/Total Volume Infused/Rate) _____

Suggestions/Conversations with Owner regarding case/treatment/prognosis/course of therapy/limitations and/or personal concerns:

PLEASE DO NOT GIVE AN ESTIMATE FOR TREATMENT OF PATIENT AT DFWNEVC.

We may try to contact you regarding case if more information is needed, or to confer with you.
Thank you for your cooperation in helping us provide care for your patients and clients.

2311 Cross Timbers Road, Suite 319 • Flower Mound, Texas 75028 • **469.464.2964** • Fax: 469.464.2971