MEDVET
Leading Specialty Healthcare for Pets

Patient Referral Information

Date: _____

MedVet Chicago
Main Campus
3123 N Clybourn Ave
Chicago, IL 60618
773.281.7110
Please fax or email this form to:
773.880.6083
info.chicago@medvet.com

- ☐ Cardiology
- ☐ Critical Care
- ☐ Dentistry
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Radiology
- ☐ Surgery

MedVet Chicago
Cancer Center
3130 N Clybourn Ave
Chicago, IL 60618
872.829.2944
Please fax or email this form to:
872.829.2934
info.chicago@medvet.com

- ☐ Medical Oncology
- ☐ Radiation Oncology
- ☐ Rehabilitation

MedVet Chicago
North Shore Campus
1812 Skokie Blvd
Northbrook, IL 75243
847.786.3030
Please fax or email this form to:
847.786.4030
info.chicago@medvet.com

- ☐ Dermatology (Thursday Only)

Emergency Follow-up Preferences:

- ☐ Call me at _____ ☐ AM ☐ PM at (_____) _____ for review
- ☐ Call my office tomorrow for standard follow-up
- ☐ Refer to MedVet Specialty Dept. if necessary
- ☐ Send client and patient to office
- ☐ Email _____ ☐ Fax Report _____

For internal use only - If referral appointment had been scheduled, please note:
Date: _____ **Time:** _____

Referring Veterinarian: _____ **Clinic/Practice Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Daytime Phone: (_____) _____ **Fax:** (_____) _____ **Evening Phone:** (_____) _____

E-mail address: _____ **Communication Preference:** ☐ Phone ☐ Fax ☐ E-mail

Client Name: _____ **Patient Name:** _____

Address: _____ **Phone:** (_____) _____

☐ **Canine** ☐ **Feline** ☐ **Other** **Breed:** _____ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age:** _____

☐ **See Records Attached**

Presenting Complaint:

History:

Physical Examination Findings:

Pertinent Laboratory Results:

Treatment Schedule:

Differential Diagnosis/Reasons for Referral: