

Date: \_\_\_\_\_

**MedVet Commerce**  
 1120 Welch Rd  
 Commerce, MI 48390  
 248.960.7200  
**Please fax or email this form to:**  
**248.960.7201**  
**info.commerce@medvet.com**  
 Emergency Medicine  
 Neurology  
 Rehabilitation

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

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Presenting Complaint:

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History:

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Physical Examination Findings:

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Pertinent Laboratory Results:

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Treatment Schedule:

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Differential Diagnosis/Reasons for Referral:

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