MEDVET
*Leading Specialty Healthcare for Pets*

# Patient Referral Information

**Date:** _____

**MedVet Indianapolis**
9650 Mayflower Park Dr Carmel,
IN 46032
317.872.8387
**Please fax or email this form to:**
**317.552.0919**
**general.indy@medvet.com**

- ☐ Dentistry & Oral Surgery
- ☐ Emergency Medicine
- ☐ Internal Medicine
- ☐ Medical Oncology
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Surgery

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:** _____ **Preference for initial communication:** ☐ 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:**