MEDVET
Leading Specialty Healthcare for Pets

Patient Referral Information

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

- ☐ Cardiology
- ☐ Emergency Medicine
- ☐ Internal Medicine
- ☐ Neurology & Neurosurgery
- ☐ 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: ____ **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: