

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

**MedVet Norwalk**  
 129 Glover Ave., Ste. 1A  
 Norwalk, CT 06850  
 203.838.6626  
**Please fax or email this form to:**  
**203.838.6640**  
**records.norwalk@medvet.com**

Emergency Medicine  
 Internal Medicine  
 Medical Oncology  
 Neurology & Neurosurgery  
 Radiation Oncology  
 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

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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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