Patient Referral Information

Date: __________

MedVet Northern Virginia
8614 Centreville Rd.
Manassas, VA 20110
703.361.8287

Please fax or email this form to 703.361.8673
info.nova@medvet.com

☐ Emergency Medicine
☐ Internal Medicine
☐ 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 ________________________

Internal Medicine Appointment Type:
☐ Ultrasound only
☐ Full consultation (Exam, Consult & Ultrasound)

Referring Veterinarian: ___________________________ Clinic/Practice Name: ___________________________
Phone: (______) __________________ Fax: (______) __________________ Email: _____________________________

Communication Preference: ☐ Phone ☐ Fax ☐ E-mail

Client Name: ___________________________ Patient Name: ___________________________
Phone: (______) ___________________________ Breed: ___________________________ ☐ Canine ☐ Feline
Sex: ☐ M ☐ MN ☐ F ☐ FS Age: ___________

Presenting Complaint:

________________________________________________________________________________________

History:

________________________________________________________________________________________

Physical Examination Findings:

________________________________________________________________________________________

Pertinent Laboratory Results:

________________________________________________________________________________________

Treatment Schedule:

________________________________________________________________________________________

Differential Diagnosis/Reasons for Referral:

________________________________________________________________________________________

☐ Records Attached ☐ Labs Attached ☐ Images Attached

Whenever possible, and if appropriate for the patient, please provide at least a year’s worth of medical records when referring your patient.