

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

**MedVet Dallas**  
 11333 North Central Expressway  
 Dallas, TX 75243  
 972.994.9110  
**Please fax or email this form to:**  
**972.994.0261**  
**info.dallas@medvet.com**

Cardiology  
 Critical Care  
 Emergency Medicine  
 Internal Medicine  
 Medical Oncology  
 Neurology/Neurosurgery  
 Surgery

**MedVet Grapevine**  
 2700 West State Hwy 114  
 Grapevine, TX 76051  
 682.223.9770  
**Please fax or email:**  
**682.223.9771**  
**infograpevine@medvet.com**

Cardiology

**MedVet Richardson**  
 401 W. President George Bush Hwy  
 Richardson, TX 75080  
 972.479.9110  
**Please fax or email:**  
**972.331.5793**  
**medvet-richardson@medvet.com**

Emergency Medicine

**Type of Care Needed:**

Emergency (same day)  
 Urgent (1-3 days)  
 First Available

**For internal use only**  
 If referral appointment had been scheduled, please note:  
**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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 \_\_\_\_\_

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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