

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

### MedVet Chicago

3305 N. California Ave.  
Chicago, IL 60618  
773.281.7110

**Please fax or email this form to:**

**773.880.6083**

**info.chicago@medvet.com**

- Anesthesia & Analgesia
- Cardiology
- Critical Care
- Dentistry & Oral Surgery
- Dermatology
- Integrative Medicine
- Internal Medicine
- Medical Oncology
- Neurology & Neurosurgery
- Ophthalmology
- Radiation Oncology
- Radiology
- Rehabilitation
- Sports Medicine
- Surgery

### MedVet North Shore

1812 Skokie Blvd.  
Northbrook, IL 75243  
847.786.3030

**Please fax or email this form to:**

**847.786.4030**

**info.chicago@medvet.com**

- Dermatology (Wednesday Only)
- Surgery (Monday-Thursday)

### 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

Presenting Complaint:

\_\_\_\_\_

History:

\_\_\_\_\_

Physical Examination Findings:

\_\_\_\_\_

Pertinent Laboratory Results:

\_\_\_\_\_

Treatment Schedule:

\_\_\_\_\_

Differential Diagnosis/Reasons for Referral:

\_\_\_\_\_