MEDVET
Leading Specialty Healthcare for Pets

Patient Referral Information

Date: _____

MedVet Mountain View
601 Showers Dr.
Mountain View, CA 94040
650.494.1461
Please fax or email this form to:
650.494.0753
info.mountainview@medvet.com
☐ Critical Care/Emergency 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 Department if necessary
☐ Send client and patient to office
☐ E-mail _____ ☐ 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: