

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

**MedVet Indianapolis**

9650 Mayflower Park Dr.  
Carmel, IN 46032  
317.872.8387

**Please fax or email this form to:  
317.552.0919**

**general.indy@medvet.com**

- Cardiology
- Dentistry & Oral Surgery
- Emergency Medicine
- Internal Medicine
- Radiology
- Rehabilitation
- 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: \_\_\_\_\_ Preference for initial communication:  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:

---