MEDVET
*Leading Specialty Healthcare for Pets*

# Patient Referral Information

**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
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Sports Medicine
- ☐ Surgery

## MedVet North Shore

1812 Skokie Blvd.
Northbrook, IL 60062
847.786.3030
**Please fax or email this form to:**
**847.786.4030**
**surgery.northshore@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:**