

METROPOLITAN VETERINARY SPECIALISTS

AND EMERGENCY SERVICE

Phone: 502-266-7007 Fax: 502-266-7375
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vets@metrovetlouisville.com

Case Referred To:

<input type="checkbox"/> Surgery	<input type="checkbox"/> Neurology
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Neurology	<input type="checkbox"/> Emergency
<input type="checkbox"/> Ophthalmology	

A phone call to our emergency service is appreciated prior to emergency referrals

PATIENT REFERRAL FORM

Date _____ Patient _____
Owner _____ Age/Weight _____
Address _____ Sex: MN M FS F
City/State/Zip _____ Species: Canine Feline Other _____
Phone _____ Breed _____

REFERRING VETERINARIAN INFORMATION

Referring Doctor: _____ Clinic: _____
Address/City/State/Zip: _____
Contact Number: _____ Email: _____

REASON FOR REFERRAL: _____

MEDICAL HISTORY: _____

PERTINENT DIAGNOSTICS FINDINGS: _____

TREATMENTS RECEIVED (including MG dosage and time): _____

What cost estimate, if any, was provided to the owner prior to referral? \$ _____

HOW WILL WE RECEIVE PATIENT'S MEDICAL RECORDS, LAB RESULTS AND IMAGING?

- Attached electronically via email
- Via Fax (502) 266-7375
- Owner will bring a copy