NOR CAL
VETERINARY EMERGENCY
AND SPECIALTY HOSPITAL
ADVANCED. COMPASSIONATE. ACCESSIBLE. 24 / 7
www.norcalvet.com

Date: ___/___/___

General Referral Form

Please include a copy of all current labwork, imaging, and patient medical record summary. Records may be submitted via email to hospital@norcalvet.com (preferred), or by fax to 415-970-5034, or sent with the client. If this is not an immediate/emergency referral, please have your client call to make an appointment.

If this is an emergency, post-op, or critical referral, please have the referring doctor contact the hospital to speak directly with the emergency clinician on-duty prior to transfer.

Referring Clinic Information:

Doctor | Phone/Cell | Email/Fax

Hospital | Address | Phone

PLEASE NOTE: To allow for optimal communication, please indicate preferred method(s) of communication

Personal Cell: _____ Hospital Phone: _____ Email: _____ Fax: _____

Patient Information:

Owner Name | Phone/Cell | Email

Owner Address

Patient Name | Species | Sex

Age/DOB | Breed | Color | Weight

Presenting Complaint/Reason for Transfer:

_____

Patient Status:

____ Healthy ____ Stable ____ Compromised ____ Critical

History:

Current Diagnostics Summary: (labwork, radiographic, pathology, etc. Please include copies of all current labs/rads)

Current Treatments/Medications: (Please have clients bring all patient prescriptions with them)

Please indicate clinician preference for continued care/treatment following referral:

Please note, all patients/clients are instructed to return/recheck with their referring clinician/hospital following discharge from NCVES.

____ Discharge to home when stable
____ Return to referring DVM/Clinic when stable
____ Continue treatment/workup
____ Specialist referral/transfer if indicated

Additional Comments/Requests: