Central Texas Veterinary SPECIALTY & EMERGENCY HOSPITAL

Powerful medicine. Exceptional care.

PATIENT REFERRAL FORM

SENDING TO (please check one) ☐ **Dermatology** ☐ **Internal Medicine** ☐ **Neurology** ☐ **Oncology**
☐ **Emergency/Critical Care** ☐ **Ophthalmology** ☐ **Rehabilitation & Conditioning** ☐ **Surgery**
(please also call CTVSEH)

pcDVM CLINIC INFORMATION

Date ______________________

Hospital Name ______________________ Telephone Number ______________________

Primary Care Veterinarian ______________________ Email ______________________

CLIENT INFORMATION

Owner Name (Primary) ______________________ Co-Owner Name (Secondary) ______________________

Address ______________________ City ______________ Zip Code ______________

Home Phone ☐ ______________ Cell Phone ☐ ______________ (please check primary contact #)

Email Address ____

PATIENT INFORMATION

Patient Name ______________________ Age/DOB ______________ Color ______________

Breed ______________________ **Please choose** and

Spayed / Neutered Vaccines Current Date of last Rabies vaccination ______________________

Drug Allergies ____

Current Medications ____

Brief History and Problem(s) ____

____

____

____

Were Radiographs taken? If YES, they will arrive by: Email Fax Client

Status of Appointment: Emergency This Week Routine

Please fax or email current lab work, biopsy reports, and medical records with this form.

SOUTH
4434 Frontier Trail • Austin, TX 78745
Tel: (512) 892-9038 • Fax: (512) 892-7811
24-Hour Emergency Care: (512) 899-0955
south@ctvseh.com

NORTH
12034 Research Blvd Svrd SB, Ste 8 • Austin, TX 78759
Tel: (512) 331-6121 • Fax: (512) 331-6591
24-Hour Emergency Care: (512) 331-6121
north@ctvseh.com

ROUND ROCK
301 Chisholm Trail • Round Rock, TX 78681
Tel: (512) 892-9038 • Fax: (512) 961-5201
24-Hour Emergency Care: (512) 961-5200
rr@ctvseh.com

CTVSEH.COM