Central Texas Veterinary
SPECIALTY & EMERGENCY
HOSPITAL

PATIENT REFERRAL FORM

SENDING TO (please check one): ☐ **Neurology** ☐ **Surgery** ☐ **Emergency/Critical Care** **(please also call CTVSEH)**
☐ **Outpatient Ultrasound (RR)**

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 circle** Canine / Feline and Male / Female

Spayed / Neutered Y or N **Vaccines Current** Y or N **Date of last Rabies vaccination** ___________

Drug Allergies ____

Current Medications____

Brief History and Problem(s)

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Where Radiographs taken? YES or NO **If YES, they will arrive by:** ☐Email ☐ Fax ☐ Client

Status of Appointment: ☐Emergency ☐ This Week ☐ Routine

Outpatient Abdominal Ultrasound ONLY

1. Primary reason for ultrasound: ____
2. Pertinent past medical history: ____
3. Is there any reason that your patient should **NOT** be fasted prior to ultrasound? Y or N
4. Does this patient have a history of reactions to anesthetic, analgesic or sedative medications? Y or N
5. We **highly recommend** all ultrasound patients be provided a "chill" protocol when arriving for their scheduled ultrasound appointment. Have you provided this patient with sedation options? Y or N

Fine Needle Aspirates

1. Does this pet have a history of any bleeding episodes associated with trauma or surgery? Y or N

****REQUIRED** - CBC demonstrating a normal PLT within 10 days of the procedure**

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

South Austin – south@ctvseh.com **Round Rock – rr@ctvseh.com**