EMERGENCY SERVICE
REFERRAL FORM

3767 Summer Avenue
Memphis, TN 38122
ph (901) 323-4564
fax (901)323-0946

555 Trinity Creek Cove
Cordova, TN 38018
ph (901) 624-9002
fax (901) 624-9014

Referring Clinic:_________________________________ Doctor:____________________

Owner:_______________________ Cell #:_________________ Work #:_____________

Address:__________________________ City:_______________ State:____ Zip_______

Patient Name:___________________ Species:______ Sex:______ Breed:_____________

Patient DOB/Age:_____________________ Patient's Weight Today:__________ lb / kg

Presenting Complaint:____

Diagnosis/ Differentials:____

____

Current medications (plus duration), laboratory findings, recent surgery, other:

- Please include the time medicine was last given or when treatments were completed
- Send radiographs and copy of blood work with owner

Instructions for Emergency Doctor:

- Please include medication dosages, route of administration, fluid type and rate

____ Bill us for the client's charges

____ Please contact me for any changes to these instructions.

____ Contact me only if you have questions about the case or for major changes.

I will be available for consultation at this telephone number:______________________________

____ Patient is to return to my hospital for continued care

____ Transfer patient to MVS for workup