

**** Please complete this form and upload to our online portal at www.vetmedaz.com/referrals/login ****

Expectations for this case

- Consult, Diagnostic Testing and Treatment at VETMED
- Please transfer patient back to my practice for treatment after diagnostic testing
- Consult Only, No Additional Diagnostics
- Other (please specify): _____

Date: _____

Have you contacted VETMED regarding this referral? Yes No

Referring Veterinarian Information

Veterinary Hospital: _____ Doctor's name: _____ Phone #: _____

How would you prefer to be contacted on this case? Phone Fax Email: _____

Client Information

Name: _____ Phone #: _____

Patient Information

Name: _____ Canine Feline Other: _____

Breed: _____ Sex: Male Female

Age / Date of Birth: _____ Spayed / Neutered: Yes No

Reason for Referral

Mobile Ultrasound:

- Abdominal Cardiopulmonary Evaluation (Echo) Thoracic Small Parts

Specialty Services:

- Internal Medicine Surgery Cardiology Emergency Outpatient Ultrasound CT Scan

Other: _____

Radiographs: Will be faxed Client will bring Email None being transferred

Medical Records: Will be faxed Client will bring Email None being transferred

Lab Results: Will be faxed Client will bring Email None being transferred

Additional Comments: _____

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You and your pet are being referred to VETMED for further evaluation. VETMED is a specialty veterinary referral practice and 24-hour care facility. Your veterinarian will be contacted with all results and treatment recommendations regarding your pet.

Instructions for Client

- We request 12 hour fasting for all abdominal ultrasound examinations and procedures requiring sedation or anesthesia. Water is OK.
- Please arrive 15 minutes prior to appointment to complete paperwork.
- Bring all current medications and special diets with you to appointment and hospital stay.

