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VETERINARY REFERRAL FORM

Please complete this form when referring patients to Maryland Avian and Exotics Veterinary Care. You can send it with the client or email it with the medical records prior to the appointment to (drcarr@marylandexotics.com) .

REFERRING VETERINARIAN/HOSPITAL INFORMATION

Referring DVM and Hospital Name: _____
Address: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Email: _____

PATIENT INFORMATION

Patient Name: _____ Species and Breed: _____
DOB: _____ Age: _____ Color: _____
Male ☐ Female ☐ Spayed/Neutered? Yes ☐ No ☐

PET OWNER'S NAME AND CONTACT INFORMATION

Name: _____
Address: _____ State: _____ Zip: _____
Home Tel: _____ Work Tel: _____ Mobile Tel: _____
Email: _____

PATIENT CASE HISTORY

Condition of patient: Healthy ☐ Stable ☐ Critical ☐
Presenting complaint/chief medical concerns: _____

_____

Reason for referral: _____

_____

Pertinent Medical History: _____

_____

Current Diagnostics/Treatment Medications (including dosages): _____

_____

Sending with patient: Copy of entire medical record ☐ Lab reports ☐ Radiographs ☐ Other ☐