BERKELEY DOG & CAT HOSPITAL SPECIAL VETERINARY SERVICES

DIRECT REFERRAL FORM

Open 24 hours 7 days a week!

- **REFERRING DOCTOR**:
  Referring DVM: _____ Hospital: _____

  DESIRED FORM OF CONTACT:

  ❒ Referral Letter ❒ Faxed Report ❒ Email: _____ ❒ Telephone Call

- **CLIENT / PATIENT INFORMATION**
  Client Name: _____ Date/Time: _____

  Home Phone: _____ Cell Phone: _____

  Pet Name: _____

  Species: _____ Breed: _____ Age: _____ Sex: ❒M ❒NM ❒F ❒SF

- **REFERRING TO:**

  ❒ Acupuncture ❒ Complementary Medicine ❒ Critical Care / Emergency ❒ Dentistry
  ❒ Dermatology ❒ Internal Medicine / Oncology ❒ Neurology ❒ Radiology
  ❒ Surgery ❒ Other: _____

- **PATIENT HISTORY:**

  _____

  _____

  _____

  _____

  _____

- **TENTATIVE DIAGNOSIS / REASONS FOR REFERRAL:**

  _____

  _____

  _____

- **TREATMENT INSTITUTED/CURRENT MEDICATIONS:**

  _____

  _____

  _____

- **YOUR SPECIFIC GOAL OF REFERRAL (IF ANY):**

  _____

- **TRANSFERRING INFORMATION:**
  ❒ Return back to rDVM ❒ Call rDVM ❒ Continue care with S.V.S. ❒ Release to owner

- **MATERIALS SENT WITH PATIENT:**
  ❒ Records/Lab Results ❒ X-rays ❒ Blood Samples ❒ Medications ❒ Other: _____

THANK YOU for this referral and we will notify you of the outcome.

2126 Haste St, Berkeley Phone (510) 848 – 5150 Fax (510) 843 – 1817