Veterinary Emergency + Referral Center of Hawaii

EMERGENCY TRANSFER FORM

Date: _____

Client: _____ Home Phone: _____ Work Phone: _____

Patient: _____ Breed: _____ Species: ❒Canine ❒ Feline

Sex: ❒Female ❒Male ❒Spayed/Neutered Age: _____ DOB: _____ Weight: _____

Referring DVM: _____ Phone: _____ Fax: _____

Referring Clinic: _____ Email: _____

Preferred Contact Method: ❒ Phone ❒ Fax ❒ Mail ❒ Email

Referred to: ❒ Emergency ❒ Internal Medicine

Problem/Tentative Dx: _____

_____

_____

Brief Summary of History + Findings: _____

_____

_____

Laboratory Data: ❒ Attached ❒Tests pending _____

Radiographs with client: ❒ CD ❒Flat films ❒None

Treatments/Medications: _____

_____

_____

Medications Due	Dose/Route	Next Due

Would you like to be called if there is a question or concern regarding the case? ❒ Yes ❒No

Phone Number: _____ How late would you like to be called? _____

Thank you for your referral. Please do not hesitate to contact us with any questions or comments on this case.

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