

VECCA USE

CASE:



VETERINARY EMERGENCY & CRITICAL CARE ASSOCIATES

1800 W. Memorial
OKLAHOMA CITY, OKLAHOMA 73134
PHONE: (405) 749-6989 • FAX: (405) 749-6994

PATIENT REFERRAL FORM¹

DATE ____ / ____ / ____ Referring Veterinarian/Hospital _____ / _____

Owner _____ Phone # _____ Patient _____

Canine Feline Breed _____ / Color _____ Age _____ Sex _____

Problems and/or Tentative Diagnosis, Treatment Received: _____

Treatment & Diagnostic Plan Requested or other Instructions for the Emergency Hospital:²

Prognosis given to client: _____

If the pet's condition alters, and we feel a change in the prognosis and/or the above treatment plan is indicated, do you want to be notified? Yes No

If Yes: Phone #: _____ at any time? _____ or up to _____ p.m./a.m.

Before we begin new/or additional treatment? _____ or treat as needed, then call _____

Other comments (e.g., financial considerations, special circumstances, sustained life support, etc.) _____

Fees

Payment by referring Hospital or Owner

If Owner please complete: Address _____

City _____ State _____ Zip _____

Return a.m. transfer by:

Owner Referring Hospital DO NOT RETURN UNTIL ICU/EMERGENCY CARE RESOLVED

¹For use when transferring patient direct from referring Hospital to The Veterinary Emergency and Critical Care Hospital.

²We try to stock all commonly used medications and those with critical care usage. Please call to check availability of medications and diets.