

Dulles South Animal Emergency & Referral Hospital



Dulles South Veterinary Center
25067 Elk Lick Road, South Riding, VA 20152

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DULLES SOUTH
ANIMAL
EMERGENCY &
REFERRAL HOSPITAL

Please include radiographs, copies of laboratory/diagnostic tests and a summary of the medical records. Referral information may be emailed, faxed, or sent with the client. Phone consultations with the veterinarian in charge of the case are welcomed and encouraged. Please have your client call to schedule an appointment after medical history has been provided.

TODAY'S DATE: _____ TIME: _____

Emergency Treatment Referral Form

rDVM INFORMATION

Hospital Name: _____ Referring Veterinarian: _____

Hospital Phone: _____ Fax: _____ Email: _____

Preferred method to update you on case: Phone Fax Email Best Time to Call: _____ AM PM

CLIENT INFORMATION

Client Name: _____ Home Phone: _____ Cell: _____

PATIENT INFORMATION

Patient Name: _____ Species/Breed: _____

Age _____ Weight: _____ Vaccinations Current?: Yes No Sex: Male Female Neutered Spayed

PATIENT MEDICAL INFORMATION

Condition of Patient: Healthy Stable Critical Moribund Allergies? _____

Presenting Problems/Diagnosis:

Diagnostic Results/Treatments/Medications:

Concerns/Requests:

DOCUMENTS & RECORDS

Check all that apply:

- Medical Records/Diagnostic Results Emailed
- Medical Records/Diagnostic Results Faxed
- Radiographs Emailed

- Radiographs sent with patient
- Medications sent with patient

**** Please Call To Schedule An Appointment. ****

Surgery Consultation or Rehabilitation (See Back of Form)

Surgery Services Referral

DIAGNOSTIC INFORMATION

Anesthetic risk classification if known? _____

Allergies/medication Reactions? _____

Diagnostic Results/Treatments/Medications:

Service Requests:

SERVICES REQUESTED

- Post-Op Requests:** Cold Laser Therapy Monitoring overnight & transfer back to rDVM
 Total Post-Op care (*including follow up visits*) Outpatient Surgery Only Surgery Consultation Only

**** Please Call To Schedule An Appointment.****

Rehabilitation Services Referral

DIAGNOSTIC INFORMATION

Are there any cardiac concerns? _____

Allergies? _____

Presenting Problems/Diagnosis:

Diagnostic Results/Treatments/Medications:

Service Requests:

SERVICES REQUESTED

- Evaluate and Treat** – May include PROM, TENS unit, Cryo/Thermal therapy, therapeutic exercises, underwater treadmill, and home therapy development.
 Underwater Treadmill Only - Wellness/weight loss/conditioning.

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