Patient Referral Form

Blue Springs Animal Hospital & Pet Resort
1201 SW US Highway 40, Blue Springs, MO 64015
816-229-1544 www.bluespringsanimalhospital.com

It's All About Caring!

Date:__________ Client Name:___________________ Primary Ph#________________ Alt. Ph#___________________

Client Notes: ____

Referring Vet:_________________________ Ph#________________ Alt Ph#________________ Fax ________________

Email _______________________ How do you prefer to be contacted? ☐ Call ☐ Text ☐ Email ☐Other___________

Should we contact you after hours if needed? ☐ Yes ☐ No ☐ Other____

Patient Name:__________________ ☐ Canine ☐ Feline Age:_____ Sex:_____ Breed:________________________

Patient Notes:____

Reason for Referral:____

Medical History (Please include past diagnostics, treatments, and outcome of tests and treatments.)

Current Medications / Treatments:

What diagnosis or differential diagnosis has been discussed with the client? What are they expecting during the referral?

Which of our doctors do you prefer for your referral? ______________________ If that doctor is unavailable may another doctor on our staff with expertise in that type of case see the patient? ☐ Yes ☐ No ☐ Other______________

PLEASE SEND COPIES OF THE MEDICAL RECORD INCLUDING DIAGNOSTIC TESTS AND/OR RADIOGRAPHS.
Records may be sent with the client, emailed to staff@bluespringsanimalhospital.com, or submitted on our website.