EMERGENCY SERVICE
REFERRAL FORM

3767 Summer Avenue
Memphis, TN 38122
ph (901) 323-4564
fax (901)323-0946

555 Trinity Creek Cove
Cordova, TN 38018
ph (901) 624-9002
fax (901) 624-9014

Referring Clinic:_____ Doctor:_____

Owner:_____ Cell #:_____ Work #:_____

Address:_____ City:_____ State:____ Zip_____

Patient Name:_____ Species:_____ Sex:_____ Breed:_____

Patient DOB/Age:_____ Patient's Weight Today:_____ lb / kg

Presenting Complaint:_____

Diagnosis/ Differentials:_____

_____

Current medications (plus duration), laboratory findings, recent surgery, other:

- Please include the time medicine was last given or when treatments were completed
- Send radiographs and copy of blood work with owner

_____
_____
_____
_____
_____
_____

Instructions for Emergency Doctor:

- Please include medication dosages, route of administration, fluid type and rate

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

____ Bill us for the client's charges
____ Please contact me for any changes to these instructions.
____ Contact me only if you have questions about the case or for major changes.
I will be available for consultation at this telephone number:_____
____ Patient is to return to my hospital for continued care
____ Transfer patient to MVS for workup