VETERINARY EMERGENCY,
CRITICAL CARE & REFERRAL CENTER

Internal Medicine Referral Form

Email: info@veccnh.com Fax: 603-431-1751

Date:_____ Referring Hospital phone:_____
Referring Doctor:_____ Referring Clinic:_____
Fax: _____ Email:_____

Client Name:_____ Phone:_____
Patient Name:_____ Breed:_____
Species: Canine/Feline Sex: Male/Female Age: _____ Weight:_____
Current Vaccines:_____

Reason for referral (brief history and physical exam findings):

_____
_____
_____
_____
_____

List any medications with dosage if available:

_____
_____
_____

Tests performed/pertinent lab findings:

_____
_____
_____

Patient health history/pre-existing conditions/tentative diagnosis:

_____
_____

Requests and comments for our specialist:

_____
_____

Please forward patient medical records, radiographs and lab results in addition to this form.

VECC - 15 Piscataqua Drive • Newington • NH • 03801 • (603) 431-3600