Bay Beach Veterinary Hospital
4340 Virginia Beach Blvd
Virginia Beach, VA 23452
Phone (757) **340-3913** Fax: (757) **340-4476**

REFERRAL FORM

Date: _____

Referring Veterinarian: _____
Hospital: _____
Owner's Name: _____ **Home Phone**: _____
Address: _____ **City**: _____ **Zip**: _____

Pet's Name: _____ **Species**: _____ **Sex**: _____ **Age**: _____ **Wt**: _____
Presenting Complaint:

_____

Tentative Diagnosis/Differential Diagnosis:

_____

Physical Exam Findings:

_____

Diagnostic Test Results (Please provide copy of laboratory results and radiographs):

_____
_____
_____
_____

Previous Treatment:
Fluid type and amount: _____
Medications (dose, route, time administered):

_____
_____
_____

Recommendations for Treatment:

_____
_____
_____
_____

Our clinican's assessment while your patient is hospitalized may dictate further treatment and /or diagnostics. Please initial below indicating your preference:
_____Call before major deviation or addition to recommended treatment.

DVM preferred contact number _____
_____ Proceed with necessary treatment.

Referral Wishes

- ☐ **Back to RDVM in the morning**
- ☐ **Treat until able to discharge**