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RECORDS REQUEST/ REFERRAL FORM

Please send any relevant information concerning the presenting problem and any laboratory analysis performed.

Please complete this form (on behalf of the client):

Client Name: _____ **Phone:** _____ **Cell:** _____

Address: _____ **City:** _____ **ST:** _____ **Zip**: _____

Patient Name: _____ **Species**: _____

Breed: _____ **DOB:** _____ **Sex**: ◯ M ◯ MN ◯ F ◯ FS

Specialty Services Requested: ☐ Neurology ☐ Internal Med. ☐ Oncology ☐ Ophthalmology ☐ Surgery ☐ Emergency

Reason for Referral:

History/Clinical Findings:

Current Medications:

Laboratory Results Summary:

What We Need:

Lab Results: ◯ Faxed ◯ Emailed

Medical Chart (at least 1yr history): ◯ Faxed ◯ Emailed

Were radiographs taken: ◯ Yes ◯ No If yes: ☐ Emailed ☐ Sent w/Owner

Referring Veterinarian: _____ **Phone** #: _____

Primary Veterinary Clinic: _____ **Fax** #: _____

**Fees are payable in full at time of service **

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Fax: (207) 885-1293 • Phone: (207) 885-1290
www.maineveterinarymedicalcenter.com
(Directions to our facility are on our website)