Eastern Iowa
VETERINARY SPECIALTY CENTER
755 Capital Drive SW, Cedar Rapids, IA 52404 (319) 841-5161

HOSPITAL REFERRAL FORM

- patients, records, images, lab data -

Date _____ Time _____

Doctor _____ Hospital _____ Phone _____

Owner _____ Pet _____ Phone _____

Species _____ Breed _____ Age _____ Sex: M F MC FS

Items accompanying patient: ❑ Radiographs ❑ Records ❑ ECG ❑ Fluids ❑ Meds ❑ Other_____

Significant diagnostics completed:

Diagnostics initiated, results pending:

Therapeutics initiated:

Tentative diagnosis:

INSTRUCTIONS FOR THE EASTERN IOWA VETERINARY SPECIALTY CENTER

Preferred course of action:

- ☐ Observation and monitor only
- ☐ Treat as emergency clinic doctors and client deem necessary
- ☐ Treat as follows:

IMPORTANT NOTE: *In recognition of changes in patient condition, doctor's evaluation, and client wishes, the Eastern Iowa Veterinary Specialty Center reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates.*

Referring Doctor _____ Clinic phone _____ Home phone _____

Call me if _____