MEDVET Lexington

Patient Referral Information

Date: _____

Please return this form to:
859.278.2719 FAX or appointments.lexington@medvet.com

☐ **Cardiology**
☐ **Emergency Medicine**
☐ **Internal Medicine**
☐ **Medical Oncology**
☐ **Ophthalmology**
☐ **Radiology**

If referral appointment has been scheduled, please note:
Date: _____ **Time:** _____

Emergency Release Preferences:
☐ Call me at _____ ☐ AM ☐PM
at (_____)_____ for review
☐ Call my office tomorrow for standard follow-up
☐ Refer to MedVet Specialty Dept. if necessary
☐ Send client and patient to my office

Referring Veterinarian: _____ **Clinic/Practice Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Daytime Phone: (_____)_____ **Fax:** (_____)_____

Evening Phone: (_____)_____ **E-mail address:** _____

Preference for initial communication: ☐ **Phone** ☐ **Fax** ☐ **E-mail**

Client Name: _____ **Patient Name:** _____

Address: _____ **Phone:** (_____)_____

☐ **Canine** ☐ **Feline** ☐ **Other** **Breed:**_____ **Sex:** ☐ M ☐ MN ☐ F ☐ FS **Age**: _____

Presenting Complaint:

_____

History:

_____

Physical Examination Findings:

_____

Pertinent Laboratory Results:

_____

Treatment Schedule:

_____

Differential Diagnosis/Reason for Referral:

_____

Radiology Only: ☐ Send Request Forms ☐ Payment Enclosed ☐ Bill Me

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150 Dennis Drive, Lexington, KY, 40503
859.276.2505 **MAIN**

Lexington

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Comments: