

Date: \_\_\_\_\_

<p><b>MedVet Indianapolis</b>            9650 Mayflower Park Dr.            Carmel, IN 46032            317.872.8387</p> <p><b>Please fax or email this form to:</b>  <b>317.552.0919</b>  <b>general.indy@medvet.com</b></p>	<input type="checkbox"/> Cardiology <input type="checkbox"/> Dentistry & Oral Surgery <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Integrative Medicine	<input type="checkbox"/> Internal Medicine <input type="checkbox"/> Radiology <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Surgery
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**For internal use only**  
 If referral appointment had been scheduled, please note:  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_

Emergency Follow-up 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 office

Email \_\_\_\_\_  Fax Report \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_ Clinic/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ Evening Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email address: \_\_\_\_\_ Preference for initial communication:  Phone  Fax  Email

Client Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Canine  Feline  Other Breed: \_\_\_\_\_ Sex:  M  MN  F  FS Age: \_\_\_\_\_

See Records Attached

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**Presenting Complaint:**

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**History:**

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**Physical Examination Findings:**

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**Pertinent Laboratory Results:**

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**Treatment Schedule:**

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**Differential Diagnosis/Reasons for Referral:**

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