PATIENT REFERRAL

bluepearl™
specialty + emergency pet hospital

Please check the hospital you are referring to:

☐ ANN ARBOR	☐ AUBURN HILLS	☐ GRAND RAPIDS	☐ SOUTHFIELD
4126 Packard Rd	3412 E Walton Blvd	1425 Michigan St NE Ste F	29080 Inkster Rd
Ann Arbor MI 48108	Auburn Hills MI 48326	Grand Rapids MI 49503	Southfield MI 48034
Phone 734.971.8774	Phone 248.371.3713	Phone 616.284.5300	Phone 248.354.6640
Fax 734.971.1783	Fax 248.371.3714	Fax 616.284.5320	Fax 248.354.0303

☐ **Acupuncture & Integrative Medicine** ☐ **Cardiology** ☐ **Critical Care** ☐ **Dermatology** ☐ **Diagnostic Imaging** ☐ **Emergency Medicine** ☐ **Internal Medicine** ☐ **Neurology** ☐ **Neurosurgery** ☐ **Oncology** ☐ **Ophthalmology** ☐ **Surgery**

Date _____ **Preferred method of communication** ☐ Email ☐ Fax ☐ Phone

Owner name _____ **Owner phone** _____

Pet's name _____ ☐ Male ☐ Female ☐ Canine ☐ Feline ☐ Neutered ☐ Spayed

Pet's breed _____

Pet's age _____ **Pet's weight** _____ ☐ kg ☐ lbs

Referring clinic _____ **Phone** _____ **Referring veterinarian** _____

I am transferring this patient to the emergency service

☐ and then, if needed, to a specialty service.

☐ and, as appropriate, discharge the patient to go home or back to my hospital.

☐ for overnight care/observation and then transfer back to my hospital in the morning.

Reason for referral _____

Relevant history/medications _____

Concurrent conditions _____

Previous diagnostics* (please fax or email)

LABORATORY
- ☐ CBC
- ☐ Chem
- ☐ UA
- ☐ Coagulation Panel
- ☐ Histopathology
- ☐ Cytology
- ☐ Thyroid Panel

RADIOGRAPHS
- ☐ Thorax
- ☐ Abdomen
- ☐ Limb
- ☐ Other _____

ULTRASOUND
- ☐ Abdomen
- ☐ Echocardiogram
- ☐ Other _____

Other _____

***Please enclose copies of all pertinent diagnostics.**

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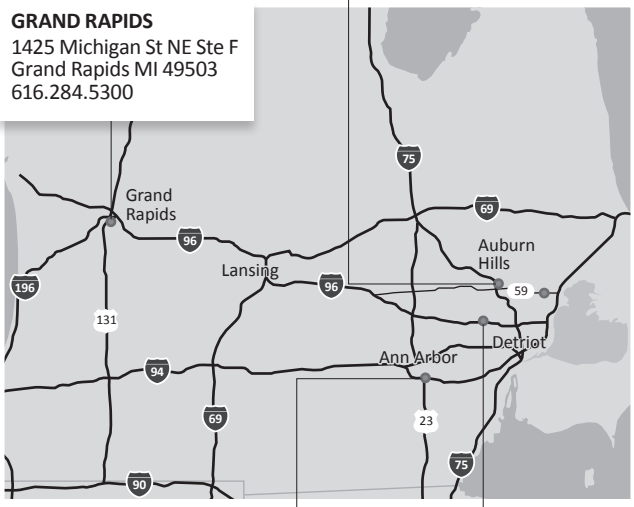
616.284.5300



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