PATIENT REFERRAL Date _____

HOPE Veterinary Specialists

☐ **HOPE Veterinary Specialists/BluePearl**
40 Three Tun Rd.
Malvern, PA 19355
Phone 610.296.2099
Fax 610.296.2444

☐ Acupuncture ☐ Dentistry ☐ Diagnostic Imaging ☐ Internal Medicine ☐ Neurology ☐ Surgery
☐ Cardiology ☐ Dermatology ☐ Emergency Medicine ☐ Interventional Radiology ☐ Oncology

Owner name _____ **Pet's name** _____

☐ Canine ☐ Female ☐ Spayed
Owner phone _____ ☐ Feline ☐ Male ☐ Neutered **Breed** _____

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

Referring clinic _____

Preferred method of communication:

☐ **Email** _____ ☐ **Phone** _____ ☐ **Fax** _____

I am transferring this patient to:

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

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

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

Reason for referral _____

Immediate history/medications _____

Concurrent conditions _____

Previous diagnostics* (please fax or email) **Date last performed** _____

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

RADIOGRAPHS
☐ Thorax
☐ Abdomen
☐ Limb
☐ Other _____

ULTRASOUND
☐ Abdomen
☐ Echocardiogram
☐ Other _____

Other _____

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