PATIENT REFERRAL

Date _____

bluepearl™
specialty + emergency pet hospital

Please check the hospital you are referring to:

☐ **GREENBRIER**
1100 Eden Way N
Chesapeake, VA 23320
Phone 757.366.9000
Fax 757.366.9582

☐ **TOWN CENTER**
364 S Independence Blvd.
Virginia Beach, VA 23452
Phone 757.499.5463
Fax 757.499.3916

☐ **After-hours Emergency** ☐ **Dermatology** ☐ **Oncology**
☐ **Critical Care** ☐ **Internal Medicine** ☐ **Surgery**

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

☐ Canine ☐ Female ☐ Spayed
☐ Feline ☐ Male ☐ Neutered

Owner phone _____ **Breed** _____

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

Referring clinic _____ **Phone** _____

Preferred method of communication ☐ Email ☐ Fax ☐ Phone

I am transferring this patient to the emergency service

☐ 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.**

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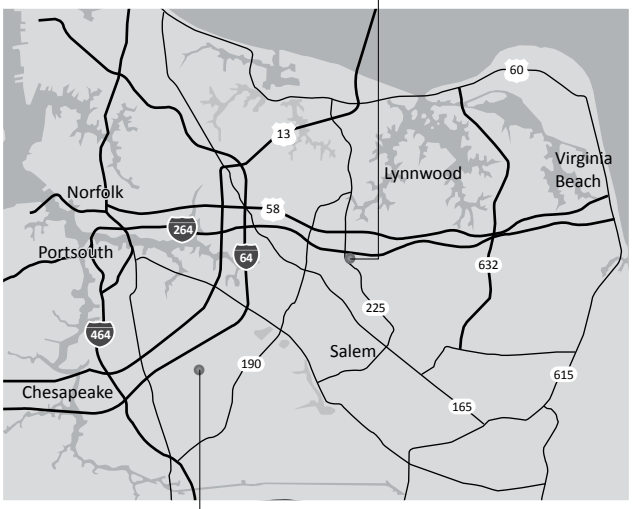

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