1640 South Queen Street
York, PA 17403
phone 717.767.5355
fax 717.764.8725

Date ____________________

Referral Information

Please complete and fax to us at the number above.
*****Please send all radiographs, bloodwork, and medical record with client*****

Referring veterinarian and practice name _____________________________________
Phone number ___________ Fax number ___________ e-mail ___________________

Client name ________________________ Client telephone ____________________
Pet name _______________________ Species _____________
Breed ______________ Age _____________ Sex ____________

Reason for referral:
- ongoing care
- critical care
- emergency evaluation
- surgical evaluation
- endoscopy
- other: _____________________

Brief history: _______________________
____
____
____
____
____
____

Working diagnosis: ____

Current treatments/medications: ____
____
____

If possible, please fax this information prior to sending the client to our facility. Our veterinarians would also appreciate the opportunity to speak to the referring veterinarian.

If you have a strong preference regarding whether the patient returns to your facility on the next business day or stays with us for the duration of their hospitalization, please indicate: ____

Thank you for your referral!