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BEND | Veterinary Specialty & Emergency Center

NEW PATIENT REFERRAL FORM

REFERRAL INFORMATION:

Referring Veterinarian: _____

Referring clinic name: _____

Phone: _____ - _____ - _____

E-mail: _____

Fax: _____ - _____ - _____

Preferred contact for records?

☐ E-mail

☐ Fax

PATIENT INFORMATION:

Owner name: _____

Patient name: _____

Species: _____ Breed: _____ Sex: _____ Age: _____ Weight: _____ ☐ lbs ☐ kg

PRIMARY CONCERN: _____

BRIEF CLINICAL HISTORY: _____

PATIENT MEDICATIONS AND INTERVENTIONS: _____

ADDITIONAL COMMENTS: _____

PLEASE SEND COMPLETE MEDICAL RECORDS TO BVS@BENDBROADBAND.COM OR (FAX) 541-318-1665.