AUBURN UNIVERSITY CVM
PATIENT REFERRAL FORM

CLIENT INFORMATION

Client Name:		
Home Phone:	Work Phone:	Cell Phone:
Current Address:		
City:	State:	ZIP Code:

Has this client had a pet seen at Auburn University CVM before? ○ Yes ○ No
Has this patient been seen at Auburn University CVM before? ○ Yes ○ No

○ I have asked client to call to schedule appointment.
○ Please call client to schedule appointment.

PATIENT INFORMATION

Patient Name:		
Species:	Breed:	Color:
Age:	Weight:	Sex: ○ F ○ FS ○ M ○ MC
Date of last Rabies Vaccination:		
Service Referring to:		
Reason for Referral:		

PATIENT HISTORY

TREATMENT

REFERRING VETERINARIAN INFORMATION

Referring Veterinarian Name:		
Clinic Phone:	Clinic Fax:	Email:
Clinic Address:		
City:	State:	ZIP Code:

SIGNATURES

I am a licensed veterinarian practicing within the United States. All of the information entered in this form is accurate and trustworthy to the best of my knowledge. If this statement is true, please type your initials in the following box:

Signature of Referring Veterinarian:	Date:

PATIENT RECORDS/LAB WORK

Supporting medical history and patient records are required in order to ensure that our clinicians, technical staff, and DVM students have the most up-to-date information regarding the referral. The faculty of the Bailey Small Animal Teaching Hospital emphasize that the basis for strong communication and a team approach to the patient's care begins with the information you provide. Patient records can be sent via fax to 334-844-0530 or by email to referral@vetmed.auburn.edu.