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# Referral Form

**Requested Referral To**: ☐ Internal Medicine ☐ Surgery ☐ Integrative Medicine/HBOT/Rehab

**REFERRAL PARTNER INFORMATION**

Referring Doctor: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ Fax: _____

Email: _____ Contact Preference: ☐ Phone ☐ Fax ☐ Email ☐ Portal

**PATIENT INFORMATION**

Client: _____ Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Breed: _____ Age: _____

Animal: ☐ Canine ☐ Feline ☐ Other Sex: ☐ Male ☐ Male Neutered ☐ Female ☐ Female Spayed

**REFERRAL REASON**

_____

_____

_____

_____

**MEDICAL HISTORY** (including presenting complaint)

**PERTINENT DIAGNOSTIC FINDINGS**

**TREATMENTS RECEIVED** (including mg dosage)

**MEDICAL RECORDS INFORMATION**

☐ Patient is arriving with a copy of the records, lab results, and/or radiographs

☐ Records, lab results, and/or radiographs have been sent via the online Veterinian's Portal (www.bgvets.com)

☐ Patient's records, lab results, and/or radiographs were faxed over (Fax 859-335-8635)