MCKNIGHT
24 HOUR VETERINARY HOSPITAL

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# Patient Referral Form

**REFERRING VETERINARY INFORMATION**

Dr. _____ Hospital Name: _____

Phone Number: _____ Fax Number: _____ Email: _____

**CLIENT INFORMATION**

Name: _____

Address: _____

Contact Number: _____ Email: _____

**PATIENT INFORMATION**

Name: _____ Breed: _____ D.O.B: _____

Sex: ☐ M ☐ F Neutered/Spayed: ☐ Yes ☐ No Colour: _____ Weight: _____

**Patient is:** ☐ CRITICAL ☐ STABLE

**Referral Reason:** ☐ No Appointments Available ☐ We Are Closed/Closing ☐ Patient Needs Overnight Monitoring

**Case Summary:** (Please attach any information such as medical records, lab results, or additional sheets)

**Lab Samples**: ☐ Coming with Client ☐ Not Collected Yet ☐ Complete and Attached

**X-Rays:** ☐ Coming with Client ☐ Not Performed Yet ☐ Emailed to info@mcknightveterinaryhospital.ca

**Checklist:**

- ☐ Medical records have been faxed
- ☐ An estimate has been prepared for the client by McKnight, they have signed and it has been faxed back
- ☐ McKnight has been called and notified of estimated time of arrival
- ☐ Client has been informed that ***if the animal is stable*** and McKnight has another critical patient, there may be a wait