REGIONAL
VETERINARY EMERGENCY AND SPECIALTY CENTER
PARTNERS IN PATIENT CARE

4250 Route 42 • Turnersville, NJ • 08012
PH 856.728.1400 FX 856.728.1811

REFERRING HOSPITAL	PATIENT INFORMATION
Hospital Name :	Client Name:
	Patient Name:
Veterinarian:	Age: Sex: M F Altered: Y N Species:
Mailing Address:	History/Exam Findings:
Phone:	
Fax:	Pertinent Lab Results:
Email:	
EMERGENCY / AFTER HOURS CARE	Procedures Performed:
☐ Overnight Care with morning return	
☐ Care through illness process	
☐ Weekend Care w/Monday return	Specific Clinical Questions or Concerns:
☐ Holiday Care	

Specialty Services

- ☐ Dermatology Consult
- ☐ Radiology Consult
- ☐ Internal Medicine Consult
- ☐ Surgery Consult

Endoscopy

- ☐ Colonoscopy
- ☐ Pharangoscopy
- ☐ Rhinoscopy
- ☐ Cystourethroscopy
- ☐ Gastric Foreign Body Retrieval
- ☐ Gastroduodescopy
- ☐ Esophogoscopy

Ultrasound Examinations

- ☐ Abdomen
- ☐ Brain (Open Fontanel)
- ☐ Lymphnode
- ☐ Liver
- ☐ Vascular
- ☐ Cervical /Thyroid
- ☐ Renal/Bladder
- ☐ Bladder Only
- ☐ Reproductive
- ☐ Musculoskeletal
- ☐ Thoracic
- ☐ Ocular

☐ **Email Treatment Plan to _____@_____**

Opt in to receive an email with a treatment plan from a Surgeon or Internist based on your ultrasound report within 24 hours.

Reason for Procedure:

Pertinent History:

DOCTORS: PLEASE COMPLETE THIS FORM FOR EACH PATIENT YOU REFER TO RVESC. REFERRAL FORM MAY BE FAXED OR SENT WITH THE OWNER TO ACCOMPANY THE PATIENT. PLEASE MAKE COPIES FOR REUSE OF THIS FORM.