CAPITAL AREA VETERINARY EMERGENCY SERVICE AND VETERINARY REFERRAL CENTER OF NEW HAMPSHIRE

REFERRAL FORM

*****Please completely fill out form so we may better serve your patient*****

Date: _______________
Patient Being Referred For:
Emergency ________
Dr. Karen Gibson, Surgery ___*Board Certified*
Dr. Stephanie Kottler, Internal Medicine _____ (practice limited to internal medicine)
Dr. John MacGregor, Cardiology____ *Board Certified*
Dr. David S. Sobel, Ultrasonographer _____

Referring Hospital:__________________________________ Hospital Phone:_______________________________________
Hospital Fax:_____________________________ Hospital E-Mail:____
Referring Veterinarian:____
Owner Name:_____________________________ Patient Name:____
Owner Phone(s):____
Other contact number:____
Species: ______________ Breed:_______________DOB:__________Gender:_____ Weight_____ BCS: _______________
Current Diet: ____
History (signs, onset, progression): ____
____
____
____
____
____
Vaccination history: ____
PE findings: ____
____
Diagnostic Results (please attach test result)*____
Current Treatments/Medications (include dosage, duration, and response): ____
____
Previous Treatments/Medications: ____
____
Additional Comments: ____
____
Additional enclosures: RADS__________________ Laboratory testing____.

Please forward all pertinent medical record information including results of laboratory tests by fax, mail, or email.

Records and radiographs may also be sent with the owner the day of the appointment. Please label radiographs with hospital name and address as well as patient name and information. These may also be sent digitally. Radiographs will be returned by mail unless otherwise specified by you.

1 Intervale Rd. Concord, NH 03301
Toll free: 1-877-929-1199 Ph: 603-227-1199 Fax: 603-227-0666
info@capareaves.com

Instructions for Owner's

If your pet may be having a procedure done while visiting our specialists please do not feed after midnight the night before. Water is permitted.