Date: _____/_____/_____

Department being referred to:

___ Emergency ___ Surgery ___ Internal Medicine ___ Oncology ___ Dermatology ___ Nutrition ___ Dentistry

Referring Doctor Information

Referring Veterinarian: _____Hospital Name: _____

Address: _____

Phone: _____Fax: _____

Email: _____

Client Information

Client Name: _____Phone: _____

Address: _____

Email: _____Alt. Phone_____

Patient Information

Patient Name: _____Breed: _____

Species: _____Age: _____Sex: _____Spayed/Neutered: _____

Presenting Complaint: _____

_____

Medical History: _____

_____

Current Medications: _____

_____

Treatment Administered: _____

_____

Diagnostics Provided: X-Rays ____ Bloodwork ____ Ultrasound ____ Urinalysis ____ Other _____

*Please remember to send copies of all tests performed to MASH prior to any consultations.

Emergency Contact

Emergency Contact: _____Phone:_____

Relationship: _____Can Approve Treatment: _____