## **College of Veterinary Medicine**

## **Veterinary Health Center Veterinary Referral Information**

REFERRAL INFORMATION	ON			
All fields are required.				
☐ Check to update cont	act information	© Emergency - Sending AS	AP: Please call 785-532-5555	Owner will Schedule
		Clinergency - Sending Asi	Ar. Flease Call 705-552-5555	Owner win Schedule
Consultation/Referral:  O Referral Re-ch		Itation w/ Possible Referral	Referral in Person	
Service Requested:				
Small Animal Ortho Farm Animal Medic	ppedic Surgery Small Animal ine/Surgery Equine Medicine	Soft Tissue Surgery Cardiolo E Equine Surgery Small An	ogy Dermatology Exotics imal Medicine Ophthalmolog	Oncology 3y
Referring DVM:				
DVM Email:				
Telephone:				
Fax:				
Address:				
Address 2:				
City:	State:	Zip	Code:	
* Please contact our Referral	Coordinator at 785-532-5555 if your	contact information changes.		
Client's Name:		Email:		
Home Phone:		Cell Phone:		
rionie i none:		CONTRONCT		
Address:				
Address 2:				
City:	State:		Zip Code:	
PATIENT INFORMATION	:			
All fields are required.				
Name:		Breed:		
Patient Sex:		Date of Birth:		
Known Allergies:				
Patient Color:		Vaccination Status:		
Reason For Referral:				
On routine medication (he	eartworm, thyroid, others):	Type:		
REFERRING DVM CONTA	CT PREFERENCES:			
Preferred Contact Method	d:			

Current Therapy (include dates and dosages):

nt History:						
nt Physical Findings:						
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
em/Tentative diagnosi	s:					
ographic findings; clinic	cal pathology and s	pecial diagnostic	exam: (please	send copy with cli	ent if available):	
ographic findings; clinic	cal pathology and s	pecial diagnostic	exam: (please	send copy with cli	ent if available):	
graphic findings; clinic	cal pathology and s	pecial diagnostic	c exam: (please :	send copy with cli	ent if available):	
graphic findings; clinic	cal pathology and s	pecial diagnostic	c exam: (please	send copy with cli	ent if available):	
graphic findings; clinic	cal pathology and s	pecial diagnostio	c exam: (please s	send copy with cli	ent if available):	
graphic findings; clinic	cal pathology and s	pecial diagnostic	exam: (please	send copy with cli	ent if available):	
	cal pathology and s	pecial diagnostic	c exam: (please s	send copy with cli	ent if available):	
	cal pathology and s	pecial diagnostic	exam: (please	send copy with cli	ent if available):	
	cal pathology and s	special diagnostic	c exam: (please	send copy with cli	ent if available):	
ographic findings; clinic	cal pathology and s	special diagnostio	c exam: (please	send copy with cli	ent if available):	
	cal pathology and s	special diagnostic	exam: (please	send copy with cli	ent if available):	

I have explained to my client that the KSU VHC charges for services rendered. Outpatients are required to pay in full

at time of discharge. Inpatients are required to pay 60% of the estimate at time of admission and the remaining balance at the time of discharge.

Print and Fax Form to (785) 532-4900

## Please Call for an Appointment

Small Animals 785-532-5690 Large Animals 785-532-5700 Referring Vet Direct Line 785-532-5555 Referring Vet Fax 785-532-4900