

**safe haven PATIENT REFERRAL FORM**

13085 Perry Hwy Wexford, PA 15090

PHONE: 724-591-8393 FAX: 724-591-8399

email : [internalmed@shvh.vet](about:blank)

urgentcare@shvh.vet

**Primary or Requesting Provider**

|  |  |  |  |
| --- | --- | --- | --- |
| **Veterinary Practice:** | | Phone: | Fax: |
| Referring Veterinarian: | Address: | | |

**Client Information**

|  |  |
| --- | --- |
| Name (Last, First): | |
| Address: | |
| Primary Contact Number: Alternate Number(s): | |
| Additional Name on Account (Last, First): | Contact Number: |
| Additional Name on Account (Last, First): | Contact Number: |

**Patient Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | | Species: Dog □ Cat □ | | Sex: F □ M □ FS □ MN □ |
| Breed: | Color: | | Age/Date of Birth: | |

**Referral Information**

|  |
| --- |
| Reason for Referral: |
| Brief History: |
|  |
|  |
|  |
| Diagnosis/ Presumptive Diagnosis: |
| Attachments: Please attach any pertinent medical records, test results, etc |
| Services Desired: Urgent Care □  IM Consultation Only □  IM Consultation with diagnostics □  *Please specify specific diagnostics your patient needs:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *Please call with any additional information or expectations*  *Results and recommendations will be sent to your facility via email unless otherwise instructed.* |