



Case Transfer Information

Date: _____ Clinic: _____
 Doctor: _____ Phone#/ hours I am reachable: _____
 E-mail: _____ Please do NOT call Call if condition changes

Client Information :

First Name	Last Name		
First Name	Last Name		
Home Phone Number ()	Other Phone Number: ()	<input type="checkbox"/> Mobile	<input type="checkbox"/> Work <input type="checkbox"/> Pager

Pet Information :

Pet's Name	Species	Breed	
	<input type="checkbox"/> Canine <input type="checkbox"/> Feline <input type="checkbox"/> Other _____		
Age or Date of birth	Sex	Spayed / Neutered	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please include copies of the medical record, laboratory reports and radiographs

Presenting Complaint :

Problem List :

Diagnostics to date :

Therapeutics:

Fluids:

<u>Medication :</u>	<u>Dose in mg :</u>	<u>Duration :</u>	<u>Route :</u>	<u>Hour last given at :</u>

Current Treatment Plan :

Responsible Party for AERC Charges : Owner Bill referring clinic

Please call and speak with an AERC veterinarian directly. Thank you!

Oakdale – 651-501-3766
 FAX – 651-501-3763
 Open 24 hours, 7 days a week

St. Paul – 651-293-1800
 FAX – 651-291-1337
 Open 24 hours, 7 days a week