ANIMAL EMERGENCY & REFERRAL CENTER OF MINNESOTA

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www.aercmn.com
aecclientemail@gmail.com

Patient Referral Form: Specialty Services

Please call the clinic for all Emergency & Critical Care Referrals

Date: _____

Urgency of case – Patient should be seen:
❍ Within 24 hours ❍ 24-72 hours ❍ >72 hours

Referring Veterinarian Information:

Clinic Name:	Phone:
Clinic Address:	City/State/Zip:
Referring Veterinarian:	Preferred Contact: ❍ Fax: ❍ Email:

Client Information:

Client Name:	Primary Phone: ❍ Home ❍ Cell
Address:	City/State/Zip:
Additional Phone: ❍ Home ❍ Cell ❍ Work	Email:

Pet Information:

Patient Name:	Species: ❍ Canine ❍ Feline ❍ Other:
Breed:	Sex:
Color:	DOB:

Requested Service:

❍Acupuncture ❍ Cardiology ❍ Dentistry ❍ Dermatology
❍ Internal Medicine ❍ Physical Rehabilitation ❍ Surgery

Were radiographs taken?	❍ No ❍ Yes ❍ Client will bring
Are there lab results?	❍ Will be faxed ❍ Client will bring ❍ None
Medical Records?	❍ Will be faxed ❍ Client will bring
Is this patient being referred for allergy testing?	❍ No ❍ Yes ❍ If yes, please refer to green book for further client instructions

Reason for Referral:

_____

Previous/Current Treatments and Medications:

_____

[Internal Use] Appt Date: Time: DVM: Called by Tech: ❍

Document all communication through Client Notes in Impromed