



1710 NC Hwy 105
Boone, NC 28607
boonevet@gmail.com
828-268-2833
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General Referral Form

Today's Date:									
Patient Information									
Owner's Last Name (Last, First):					Patient's Name:			Species:	
Street Address:					Breed:		Color:		Age:
City:		State:	ZIP Code:		Sex: Male Altered Female Intact		Weight:		
Email:					Home Phone Number:			Cell Phone :	
rDVM Information									
Referrring Veterinarian:					Practice/Hospital Name:				
Practice/Hospital Address:							Practice Phone Number:		
Practice Fax Number:		City:			State:		ZIP Code:		
Email:							Best time to call:		
Patient Case History									
Condition of Patient: Healthy Stable Critical Moribund									
Reason for referral:									
Medical History/Clinical Signs:									
Vaccination Status (please list types and dates given):									
Diagnostics and Procedures (Summaries and/or attach pertinent records):									
Current Treatments/Medication (please include dosage and datesif posible):									
Sending with Patient (please circle all that apply): Copy of entire medical records Lab Reports Radiographs ECG Other medical records (please specify):									
I have reviewed and completed this form for submission to AEPCC for the evaluation of my patient.									
<div style="text-align: center;"> <hr style="width: 40%; margin: 0 auto;"/> Referring Veterinarian Signature </div>									

Pertinent medical records may also be scanned and emailed to us **OR** faxed along with the referral form. Medical records may also be brought along to the visit.