VETERINARY TEACHING HOSPITAL
WASHINGTON STATE UNIVERSITY

Patient Referral Form

PO Box 647060, Pullman, WA 99164-7060, (509) 335-0711 Fax: (509) 335-3330

DATE:_____

SERVICE REFERRED TO: _____ **VETERINARIAN (if known):**_____

REFERRING VETERINARIAN: Dr. _____

Address: _____
Telephone: (_____) _____

CLIENT'S NAME: _____

Address: _____

Address: _____

Telephone: (_____) _____

TRAINER'S NAME AND ADDRESS: _____

Address: _____

Telephone: (_____) _____

PATIENT: Species: _____ Sex:_____ Birth Date: _____ Color: _____

Markings: _____ Breed: _____

Name: _____ Use: _____

Most recent vaccination dates: _____

Known allergies or drug reactions: _____

Insured? Yes _____ No _____

HISTORY: (Attach second page if needed):

Drugs Given & Response (include dates):

Laboratory Data:

Special Requests:

(append lab reports and additional information as needed)