Emergency Animal Hospital of Collin County

Date: _____

Referring DVM: _____ Hospital: _____

Okay to call referring veterinarian: ☐ Yes ☐ No Referring DVM contact number: _____

Owner's name: _____ Patient name: _____

History of Problem/Working diagnosis:

Workup completed:

Bloodwork: ☐ complete ☐ Pending ☐ Submitted with this record

Urinalysis: ☐ complete ☐ Pending ☐ Submitted with this record

Radiographs: ☐ complete ☐ emailed ☐ Sent with client

Treatments completed:

IV fluids Type: _____ Rate: _____mls/hr Additions: _____

Medication	Amount (mg)	Route	Time
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm

Treatments requested:

IV fluids ☐ Continue IV fluids of similar type and rate. (Substitution allowed as indicated.)

Medication	Amount (mg)	Route	Time
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm
			☐ am ☐pm

Discharge/Transfer:

☐ Back to referring DVM unless declining.

☐ Release to owner if indicated.

☐ Transfer to specialist.

Additional treatments/comments:

Phone: 214/547-9900 Fax: 214/547-9911