REGIONAL
VETERINARY EMERGENCY AND SPECIALTY CENTER
PARTNERS IN PATIENT CARE

4250 Route 42 • Turnersville, NJ • 08012
PH 856.728.1400 FX 856.728.1811

REFERRING HOSPITAL	PATIENT INFORMATION
Hospital Name :	Client Name:
	Phone:
Veterinarian:	Email:
Mailing Address:	Patient Name:
	Age: Sex: M F Altered: Y N Species:
Phone:	History/Exam Findings:
Fax:	
Email:	Pertinent Diagnostic Results:
EMERGENCY / AFTER HOURS CARE	
☐ Overnight Care with morning return	Procedures Performed:
☐ Care through illness process	
☐ Weekend Care w/Monday return	Current Medications:
☐ Holiday Care	

Specialty Services	Endoscopy	Endoscopy
☐ Cardiology Consult	☐ Colonoscopy	☐ Gastric Foreign Body Retrieval
☐ Dermatology Consult	☐ Pharyngoscopy	☐ Gastroduodenoscopy
☐ Internal Medicine Consult	☐ Rhinoscopy	☐ Esophagoscopy
☐ Surgery Consult	☐ Cystourethroscopy	
☐ Radiology Consult		

Ultrasound Examinations

☐ Abdomen	☐ Liver	☐ Renal/Bladder	☐ Musculoskeletal
☐ Brain (Open Fontanel)	☐ Vascular	☐ Bladder Only	☐ Thoracic
☐ Lymph Node	☐ Cervical /Thyroid	☐ Reproductive	☐ Ocular

Email Treatment Plan to ________________________________

Opt in to receive an email with a treatment plan from a Surgeon or Internist based on your ultrasound report within 24 hours.

Reason for Procedure:

Additional Pertinent History:

DOCTORS: PLEASE COMPLETE THIS FORM FOR EACH PATIENT YOU REFER TO RVESC. REFERRAL FORM MAY BE FAXED OR SENT WITH THE OWNER TO ACCOMPANY THE PATIENT. PLEASE MAKE COPIES FOR REUSE OF THIS FORM.