PIEPER VETERINARY

Pieper Veterinary
ER & Specialty Referral Request

Referring Veterinarian

Name: _____ **Clinic:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Client Information

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Patient Information

Name: _____ **Species:** _____ **Breed:** _____

Sex: _____ **DOB / Age:** _____ **Weight:** _____ **Rabies Exp Date:** _____ ☐ Rabies Status Unknown

Department to which patient is being referred

☐ **Avian & Exotics** ☐ **Emergency Services** ☐ **Internal Medicine** ☐ **Neurology/Neurosurgery**

☐ **Oncology** ☐ **Surgery** ☐ **Physical Therapy (Berlin Street)** ☐ **Acupuncture (Berlin Street)**

for Outpatient Ultrasounds, please use our Outpatient Ultrasound Request form

Primary Complaint: _____

_____

_____

History: _____
(please attach or email a copy of the medical record)

_____

_____

Diagnostics: _____
(please email or send a copy with the owner)

_____

_____

Treatments/Medications: _____

_____

_____

Client Communications: _____

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