Referral Information Form

Pine Ridge EQUINE HOSPITAL

Referring DVM _____
Address _____
_____
Phone # _____
Fax # _____
Email _____

Client Name: _____ Phone # _____
Patient Name: _____ Age _____ Breed _____ Sex _____

Reason for referral: _____

Vaccination status: _____

Current therapy (include dates & dosages): _____

History: _____

Physical findings: _____

Problem/Tentative diagnosis: _____

Radiographic findings; clinical pathology & special diagnostic exam (please attach copies of results, if available): _____

Additional information: _____

I have explained to my client that Pine Ridge Equine Hospital charges for services rendered. Outpatients are required to pay in full at time of discharge. Inpatients are required to pay 50% of the estimate at time of admission and the remaining balance at time of discharge.

Referring Veterinarian Signature: _____ **Date:** _____

Please call (918) 827-8000 for an appointment or to visit one of our doctors.
2281 West 171st Street South
Glenpool, Oklahoma 74033
Fax: (918) 827-8001