# Riverbend Animal Hospital — Referral Form

*Please print, complete, and submit the following information to refer your patient to us.*

**Date** _____ **Referring Veterinarian** _____ **Hospital** _____

**Please select one** ☐ Owner to call for an appointment ☐ Riverbend should call owner for an appointment

**Patient Information**

Owner Name _____

Day Phone _____ Evening Phone _____ Cell Phone _____

Address _____

Pet Name _____

Species _____ Breed _____ Color _____ Sex_____

Age (years/months) _____ Weight (lbs) _____

**Medical History**

Rabies Vaccination Date _____ FVRCP/DA2P _____

Other Vaccinations and Dates _____

FeLV/FIV Test _____ Heartworm Test _____ Lyme Test _____

**Past History**

_____

_____

**Presenting Problem**

_____

_____

**Physical Exam Findings /Tests /Radiographs**

_____

_____

_____

**Recent/Current Therapy**

_____

_____

**Diagnostic Materials Sent**

_____

_____

## Please FAX this form to us at 413-587-0037

Riverbend Animal Hospital • 43 Russell St., Hadley, MA 01035 • 413-587-3737 • www.riverbendanimal.com