Route 66 Veterinary
Emergency & Critical Care Center

PATIENT REFERRAL FORM

DATE _____

REFERRING HOSPITAL INFORMATION

Referring Veterinarian _____

Referring Hospital _____

Hospital Phone # _____

Fax _____ Preferred Y / N

Email _____ Preferred Y / N

CLIENT INFORMATION

Name _____

Address _____

_____

Phone _____

Email _____

PATIENT INFORMATION

Name _____ ☐ Male ☐ Female ☐ Spayed/Neutered

☐ Canine ☐ Feline ☐ Avian ☐ Reptile ☐ Rodent ☐ Other _____

Breed _____ Color _____

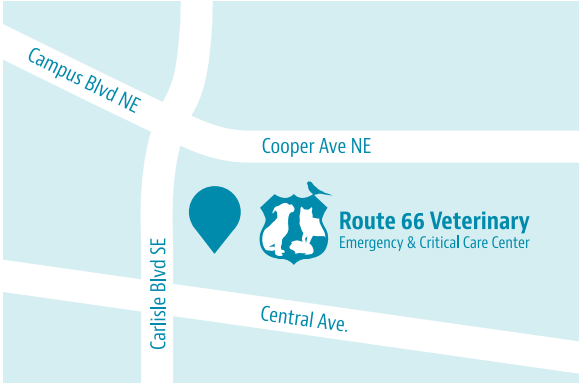
Date of Birth _____ Weight _____ Allergies _____

History of Seizure ☐ Yes ☐ No

REASON FOR REFERRAL

Radiographs	☐ Client will bring	☐ Emailed to **referral@rt66vet.com**	☐ None
Medical Records	☐ Client will bring	☐ Emailed to **referral@rt66vet.com**	☐ None
Lab Results	☐ Client will bring	☐ Emailed to **referral@rt66vet.com**	☐ None

Find us at our NEW LOCATION



3601 Central Ave NE
Albuquerque, NM 87108
(505) 266-7866

www.Rt66Vet.com
referral@rt66vet.com
fax: (844) 269-6728

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OVERNIGHT/WEEKEND TREATMENT ORDERS

FLUID THERAPY

Fluid Type _____ Rate _____ Additives _____

MEDICATIONS

	Medication	Dose	Route	Frequency	Time Next Due
1.					
2.					
3.					
4.					
5.					
6.					

Oxygen Therapy Needed? ☐ Yes ☐ No

Advanced Patient Monitoring (continuous ECG, BP, Pulse Ox, etc.)

	Monitor	Frequency	Time Next Due
1.			
2.			
3.			

Laboratory Monitoring (PCV/TP, BG, etc.)

	Test	Frequency	Time Next Due
1.			
2.			
3.			

Additional Instructions _____

_____

☐ **Please contact me** if any changes need to be made to the treatment plan

Contact Numbers (_____) _____ or (_____) _____ Text message Y / N

Please do not call me after _____

☐ **Please adjust treatment plan** at your discretion

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