



**Companion
Animal**

SPECIALTY & EMERGENCY HOSPITAL
24/7 Peace of Mind

1095 Pingree Road, Suite 120 | Crystal Lake, IL 60014
T: 815.479.9119 | F: 847.854.9119 | **CASEhospital.com**

PATIENT REFERRAL FORM

Date _____

REFERRING INFORMATION

++ Please call us directly if this is a Stat Referral ++

Veterinarian:		Hospital:	
Phone:	Fax:	Email:	

Client MUST call to schedule an appointment for our specialty services.

I am referring to the following service:

- Emergency/Critical Care — *ER@casehospital.com*
 Surgery — *SR@casehospital.com*
 Integrative Medicine (Rehab) — *Rehab@casehospital.com*
 Other: _____
 Internal Medicine — *IM@casehospital.com*

In order to expedite best quality medical care, please include all PERTINENT medical records/notes, laboratory results with referral and send radiographs via email to the appropriate department (see above), or send with the pet owner.

CLIENT INFORMATION

Client's Name:		Home Phone:		
Address:		City:	State:	Zip:
Work Phone:	Cell Phone:	Email:		

PATIENT INFORMATION

Pet's Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M/N <input type="checkbox"/> F/S
Species:	Breed:	Color:	Weight: _____ # _____ kgs

Presenting Complaint/Problem List:

Tests Performed/Pending:

Treatments Performed:

Medications:

Concurrent/Long-term Medical Conditions:

Additional Comments: