TVAEC REFERRAL FORM

Tri-Valley Animal Emergency Center
7111 Amador Plaza Rd.
Dublin, CA 94568

Referring Hosp: _____

Referring Vet: _____

Date: _____

Return to your hospital in AM ❒
Request VSA/VMS in AM ❒
Call me before *any* transfer ❒
Transfer as client chooses ❒

Feel free to call us at any time:
Phone: 925.771.5630 / Fax: 925.771.5631

Client Name: _____ **Client Phone #:** _____

Patient Name: _____

Species: _____ **Breed:** _____ **Sex:** _____ **Age:** _____ **Current Weight:** _____

Attached Medical Record? ❒ Yes ❒ No

Quick case summary: _____

_____

_____

_____

_____

_____

Recent lab work: Yes No Idexx Antech **Date:** _____

Recent X-rays: Yes No **Comments:** _____

IV Catheter: Yes, date placed: _____ No **Fluid Type?:** _____

Fluid Volume Today _____ **-or-** **Fluid Volume in last 24 hrs** _____

Medications given today:

Drug _____ Dose _____ Route _____ Time _____
am pm

Drug _____ Dose _____ Route _____ Time _____
am pm

Drug _____ Dose _____ Route _____ Time _____
am pm

Drug _____ Dose _____ Route _____ Time _____
am pm

Treatment Requests: _____

_____

_____