



Winnipiesaukee Veterinary Emergency Center, PLLC

Referral Form

Date: _____

Referring Hospital: _____ Hospital Phone: _____

Hospital Fax: _____ Hospital e-mail: _____

Referring Veterinarian: _____

Owner Name: _____ Patient Name: _____

Owner Phone(s): _____

Species: _____ Breed: _____ DOB: _____ Age: _____ Sex: _____

Referral For:

_____ Emergency = Estimated Time of Arrival? _____

_____ David Sobel, DVM, MRCVS = Appointment Date: _____

_____ Nick Cassotis, DVM, DACVO = Appointment Date: _____

History (Presenting Problem/Diagnosis): _____

Diagnostic Results: _____

Current Treatment/Medications: _____

Previous Treatments/Medications: _____

Vaccination History: _____

Additional Comments: _____

Please forward all pertinent medical record information including results of laboratory tests by fax or email.

Records and radiographs may also be sent with the owner the day of their arrival.

Additional Enclosures: X-Rays: Yes or No Blood Work: Yes or No

Instructions for owners: If your pet may be having a procedure done while visiting our specialists please do not feed after midnight the night before. Water is permitted.

8 Maple Street, Suite #2
P.O. Box 924
Meredith, NH 03253

Phone: (603) 279-1117
Fax: (603) 279-1109
E-mail:

WinniVetEr@metrocast.net

www.winnipiesaukeeveter.com

