



BEVS

Tom Hecimovich, DVM
Jodi Halpin, DVM
Hannah Flynn, VMD
Eric Patrin, DVM

PATIENT REFERRAL FORM

200 Commerce Street, Williston, VT 05495

P (802)863-2387

F (802)863-2348

Date: _____

Patient Referred To:

- | | |
|--|---|
| <input type="checkbox"/> Emergency / Critical Care | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Radiology/Diagnostic Imaging |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Physical Therapy |

Emergency Room Release Preferences:

- Call me at () _____ at _____ AM / _____ PM for review
- Fax /email medical records to my office tomorrow for standard follow-up
- Refer to specialist if necessary
- Send client and patient to my office



Bryan Harnett, DVM
Diplomate, ACVIM



**Burlington
Veterinary
Specialists**

Kurt Schulz, DVM
Diplomate, ACVS

Katie Cross, DVM,
CCRP

LYNKS GROUP
VETERINARY IMAGING

Lynn Walker, VMD
Practice Limited to
Radiology

Mark Saunders, VMD
Diplomate, ACVR



**VERMONT
VETERINARY
EYE CARE**

Sarah Hoy, DVM, MS
Practice Limited to
Ophthalmology

Referring Veterinarian: _____ Hospital Name: _____

Daytime Phone: () _____ Fax: () _____

Evening Phone: () _____ Email address: _____

Referring Veterinarian Preference for initial communication: TELEPHONE FAX EMAIL

Client Name: _____ Patient Name: _____

Client Phone: H () _____ C () _____ W () _____

Canine Feline Other _____ Breed: _____ DOB/Age: _____ Sex: M M/N F F/S

Presenting Complaint:

History:

Physical Exam Findings:

Related Laboratory and/or Radiograph Results:

Medications / Treatment Schedule:

Differential Diagnosis for Referral: