



**IRVINE
REGIONAL
ANIMAL
EMERGENCY
HOSPITAL**

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REFERRAL FORM

Referring Veterinarian	
Hospital	
Fax	
Lab Name & Acct # for Pending Tests	

Owner	
Pet's Name	
Signalment	
Pet's Disposition	
Condition	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Critical
Working Diagnosis	<input type="checkbox"/> Open
<small>Note: If you would like to transfer a patient without its owner, you must have an account with us and provide your overnight/weekend contact information. Otherwise patients must be accompanied by their owners.</small>	

Medical History (Please include radiographs and copies of relevant lab tests)

PRESENTING PROBLEM:

Referral Expectations

My expectations for overnight/weekend care are...

I have made prior arrangements for transfer to SCVRG DVM: _____

We appreciate your referral and will do our best to match your expectations. However, we reserve the right to change diagnostic/therapeutic recommendations if necessary. If you would like to be consulted about major changes, please state your preferences and contact information on our Veterinarian Preference Survey.