

ANIMAL MEDICAL CENTER

ADVANCED TREATMENT, RESEARCH, EDUCATION, DEVOTION, SINCE 1910

510 East 62nd Street New York, NY 10065
Referral Coordinator Office • (212) 329-8890 Fax • (212) 832-5417
www.amcny.org

Patient Referral Form

Date: _____

Have you called The AMC about this referral? Yes No

Referring Veterinarian Information:

Veterinary Hospital _____

Doctor's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

How would you prefer to be contacted on this case?

Phone: _____ Fax: _____ E-mail: _____

Client Information:

Client Name: _____

Phone: _____ E-mail: _____

Patient Information:

Name of animal: _____ Canine Feline Other _____

Breed: _____ Sex: _____ DOB: _____

Requested Service:

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Internal Medicine |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Surgery | <input type="checkbox"/> Diagnostic Imaging |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Oncology | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Dentistry | <input type="checkbox"/> Other _____ |

Patient Should Be Seen:

- within 24 hrs within 24-72 hrs > 72 hrs

X-Rays:

- Yes
 No
 Client will bring

Medical Records

- Will be faxed
 Client will bring

Lab Results:

- Will be faxed
 Client will bring
 None

Expectations For This Case:

- Consult only. Please return to my office for diagnostic testing and treatment.
- Please manage the diagnostic testing and treatment at the AMC.

Reason For Referral:

Past Relevant History:

Previous/Current Treatment(s) or Medication(s)

Referred Patient Appointment Information (for AMC internal use)

Doctor: _____ Date: _____ Time: _____