



800 W. Jericho Tpke, Huntington NY 11743
Phone: (631) 923-3210 Fax: (631) 367-8130
www.WHAECC.com

Referral Form

Date: _____

Referring Hospital Name: _____

Phone #: _____

Fax #: _____

Referring Veterinarians Name: _____

Referring DVM/ Hospital Email: _____

Which method of communication would be most convenient to receive Admission and Discharge Summaries of your patients?

Email Fax Mail Combination (please list): _____

Clients Name: _____

Clients Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Patients Name: _____ Age/DOB: _____ Sex: _____

Species/Breed: _____ Color: _____ Weight: _____

Please Select Service:

- Emergency & Critical Care Center**
- Rehabilitation Services** - Victoria Kearns, LVT, CCRP, NCM
- Surgery** - Dr. Matthew Raske, DVM, DACVS-SA & Dr. Donny Astor, VMD, DACVS-SA
- Cardiology** - Dr. Keith Blass, DVM, DACVIM (Cardiology) & Dr. Dennis Trafny, DVM, DACVIM (Cardiology)

Presenting Complaint: _____

Brief History: _____

Current Diagnostic Tests (including pending results): _____

Current Treatment and Medications: _____

*Please fax over all history/diagnostic tests (including pending) with the form to (631) 367-8130 or have your client bring with them, if possible. This form can be accessed from our website at www.WHAECC.com

Thank you for your referral!