



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, OACM
- Surgery** - Dr. Matthew Raske, DVM, DACVS-SA, Dr. Ariel Kravitz, DVM, DACVS-SA & Dr. Mark Levy, DVM, DACVS-SA
- Cardiology** - Dr. Keith Blass, DVM, DACVIM (Cardiology)
- Oncology** - Dr. David Hunley, DVM, DACVIM (Oncology)
- Dentistry** - Dr. Donald DeForge, VMD (Practice limited to Dentistry)
- Acupuncture & Integrative Medicine** - Dr. Dawn Greenberg, DVM, CVA

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) 367T 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!