



CVES Patient Transfer Form

Referral consult \$176.00

Once fully completed, please send with referred patient.

Referring Clinic: _____ Veterinarian: _____

Date: _____ RV Discharge Time: _____

CLIENT DETAILS

Name: _____ Surname: _____
Phone Number: _____ **Secondary Contact:** _____

PET DETAILS

Pet's Name: _____ Species: _____ Breed: _____
 Colour: _____ Age: _____ Sex: _____ Desexed: _____ Weight: _____

CLINICAL DETAILS

Diagnosis: _____ History Attached:
 Lab work performed: Y / N - Information attached Imaging performed: Y / N – Images attached
 Diagnostics needed (transfers only): _____
 Extra Information: _____
 Special instructions: _____

MEDICATION REQUIRED

Drug Name	Dose mg/kg	Route	Frequency	Last Given	Next Due	Supplied

FLUID THERAPY PLAN

Fluid Type	Additive 1	Additive 2	Rate in ml/hr	Supplied

Nursing care plan: _____

TPR: Q4 / Q6 Recumbency Care: Y / N Bladder Care: Y / N Other: _____

Food: Y / N Type: _____ Frequency: _____ Water: Y / N **NPO: Y / N**

Discharge Home: Y / N Discharge Instructions Supplied: Y / N Refer Back: Y / N

Meds to go home supplied: Y / N / None Recheck arranged: Y / N / Not nec