Patient Referral Form

P: 206-204-3366
F: 206-204-3858

Regular Referral for Internal Medicine

Animal Medical Center of Seattle

Client & Patient Information		Referring Doctor Information	
Client Name		Primary DVM	
Patient Name		Hospital	
Client Phone		Address	
Lab Used		DVM Phone	
Lab Acct. #		DVM Fax	

Prognosis given client: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Grave

Brief Case History

Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.

Referral Request

As the referring veterinarian my expectations for this case are as follows (check one)

☐ 1. Referral for the following procedure(s):

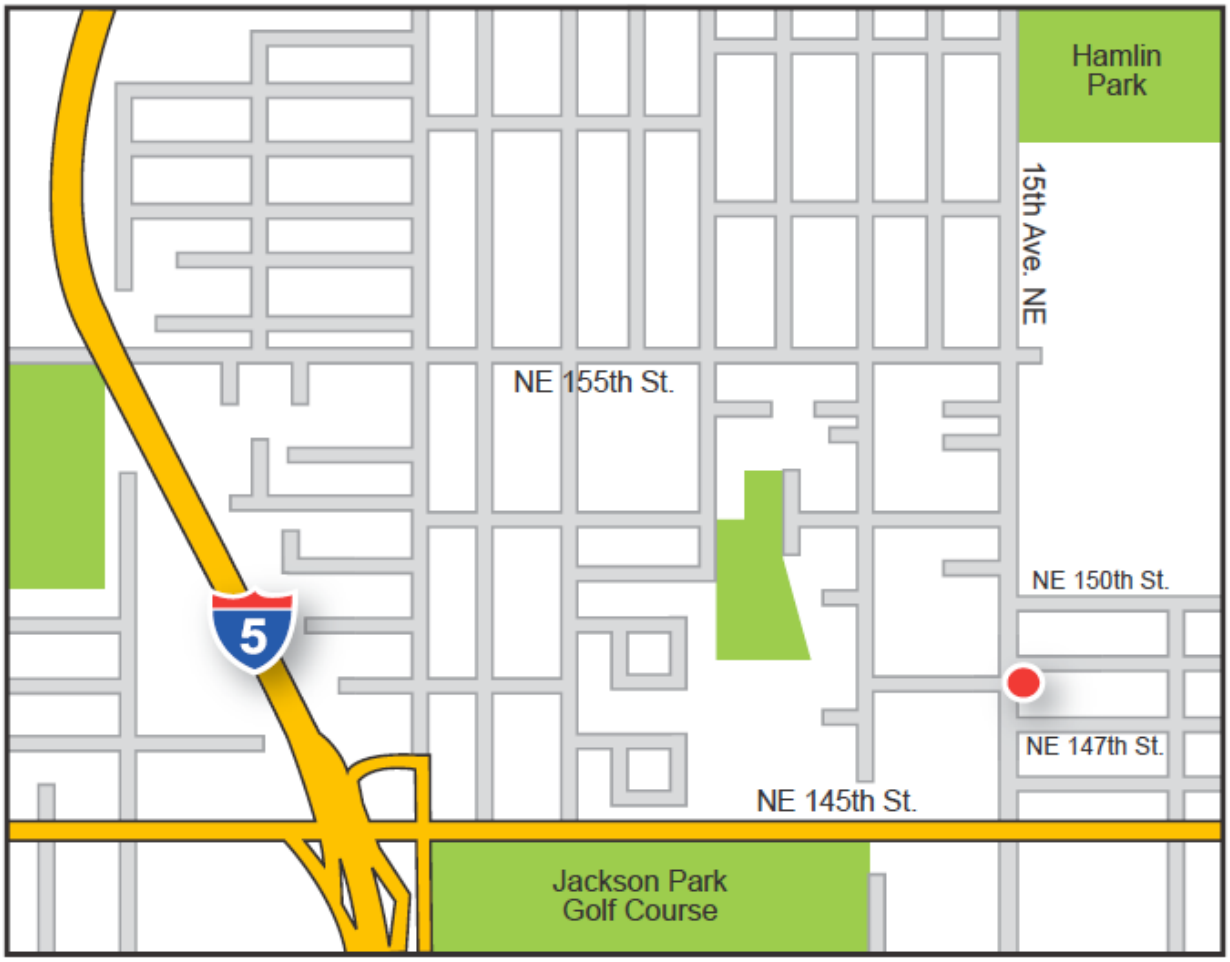
_____

☐ 2. Hospitalization for definitive care

☐ 3. Overnight care and return in the morning

Important note: In recognition of changes in patient condition, doctor's evaluation and client wishes, AMCS reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates.

THANK YOU FOR YOUR REFERRAL. DIRECTIONS TO THE FACILITY ARE ON THE BACK OF THIS FORM.



From I-5 Northbound:

Take exit **175** toward **WA-523/NE 145th St**
Slight **left** at **5th Ave NE**
Take the 1st **right** onto **NE 145th St/WA-523 E**
Turn **left** at **15th Ave NE**
Destination will be on the right

From I-5 Southbound:

Take exit **175** for **WA-523/NE 145th St** toward **5th Ave NE**
Turn **left** at **NE 145th St/WA-523 E**
Turn **left** at **15th Ave NE**
Destination will be on the right

14810 15th Avenue NE, Suite B, Shoreline, WA 98155