Powers Pet EMERGENCY

Emergency Care / Post-Operative Care at Powers Pet Emergency

PLEASE COMPLETE THIS FORM AND RETURN VIA FAX 719-550-5771

Referring Veterinarian

Referring DVM _____

Hospital Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax_____

E-Mail _____

Preferred Method of Contact: Phone / Fax / E-Mail

Patient Information

Owner's Name _____

Pet's Name _____

Species _____ Age _____

Breed _____ Sex: M / NM / F / SF

Diagnosis _____

Previous Medical Conditions _____

_____

Brief Medical History: _____

_____

_____

Latest Treatments / Medications Administered: _____

_____

_____

Pertinent Lab Work: _____

_____

_____

Special Procedure / Treatment Requests: _____

_____

_____

PLEASE BRING ALL PERTINENT X-RAY FILMS, LAB WORK, AND MEDICAL RECORDS FOR SUBMISSION TO EMERGENCY CARE DOCTOR.
FULL MEDICAL RECORDS WILL BE REPORTED TO THE REFERRING VETERINARIAN.