Fairfield Animal Hospital Emergency Patient Transfer

OWNER FIRST/LAST NAME:	**PATIENT NAME:**
ADDRESS - including postal code:	**BREED:**
	SEX: F / FS / M / MN
ALL contact phone numbers:	**DOB:**
Regular DVM if different:	**COLOR:**
Special Diet:	***WEIGHT IN KG:**

Reason for transfer/DDX: _____

History: _____

_____

_____

Exam Findings: _____

_____

_____

_____

Bloodwork: ☐ **Transferred with Patient** ☐ **Emailed**

Bloodwork Findings: _____

_____

_____

Radiographs: ☐ **Transferred with Patient** ☐ **Emailed**

Radiograph Findings: _____

_____

_____

Communication with owner: _____

_____

_____

Medications Given:

Medication (include dosage)	Route given: Oral/IV/SQ/IM	Amount Given:	Time Given:

IV fluids: ☐ **Patient transferred on IV fluids**

Type: LRS, Isolyte, NaCl etc	Supplementation: KCl, Hemostam, Ca+, Mg+, etc	Time Started	Rate (ml / hr)

☐ **On Pet Insurance Name of company:**_____

<u>Referring DVM:</u> Please include an emergency contact number - this will only be used in cases where emailed information has failed to come through, or inability to read transfer information

DVM Name:_____ **Contact Phone #:**_____

PLEASE CALL FAIRFIELD AT 250-860-6550 TO ARRANGE PICK UP TIME IF NECESSARY

Referring Clinic:	Referring Veterinarian:

☐ **Dr. Bhandal surgical consult** ☐ **Dr. Reimer Ultrasound** ☐ **Dr. Ganton Endoscopy**

Special Requests:_____

_____

_____

_____

1987 Kirschner Rd, Kelowna, B.C. V1Y 4N7 ph: 250-860-6550 F: 250-860-8511
Email: fairfieldanimalhosp@gmail.com