



SMAEC REFERRAL SHEET

TELEPHONE: 952-953-3737

FAX: 952-953-4453

Referring Clinic: _____ Date: _____

Referring Veterinarian: _____ After hours Phone: _____

Would you like to be contacted by SMAEC ? ____ Yes ____ No

If yes, under what circumstances? _____

Client Name: _____ Telephone: _____

Patient Name: _____ Species: _____ Age: _____

Weight: _____ Breed: _____ Color(s): _____

Patient history (Please provide copies of current lab work): _____

Diagnosis/Tentative Diagnosis: _____

If on IV Fluids: Date Catheter placed: _____ Volume infused: _____

Fluid used: _____ Additions to fluid: _____

Current Medications:

Medication Name & Strength	Freq & Route of Admin	Time of next dose

Patient care protocol to be determined by a SMAEC Veterinarian

Recommended patient care protocol: _____

Please send this form and all relevant medical documents with your client or fax to : 952-953-4453