Date: - -200

Direct Transfer Form

Transfer Information

Hospital REFERRING HOSPITAL _____ REFERRING DR. _____

YOUR PHONE # FOR TONIGHT: _____ FOR 8:00 AM _____

Owner LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ ALT. PHONE _____

Patient PATIENT NAME _____ AGE _____

SPECIES: FELINE / CANINE / OTHER: _____ GENDER: MALE / FEMALE SPAYED / NEUTERED

BREED: _____ COLOR: _____ WEIGHT _____

DO WE HAVE AUTHORIZATION TO BILL YOUR HOSPITAL? YES NO SIGNED: _____

WHO WILL PICK UP THE PATIENT IN THE MORNING? CLIENT HOSPITAL

Medical Information

IF THE SITUATION ARISES, SHOULD ATTEMPTS BE MADE TO RESUSCITATE?
(PLEASE ADVISE CLIENTS THAT CPR COSTS START AT $100) **YES (CPR)** **NO (DNR)**

CASE HISTORY _____

PE FINDING / LAB RESULTS _____

AEC Treatments

FLUIDS

FLUID TYPE	ADDITIVES	RATE	BOLUS?	SENT

TREATMENTS / MEDICATIONS

DESCRIPTION	HOW OFTEN	STARTING	REFRIGERATE	SENT

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