



## Referring Veterinarians: Emergency Intake Information

Date: \_\_\_\_\_ Pet Name: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Species: \_\_\_\_\_  
Address: \_\_\_\_\_ Age/DOB: \_\_\_\_\_ Breed: \_\_\_\_\_  
\_\_\_\_\_  
Male: \_\_\_\_\_ Female \_\_\_\_\_ Neutered? \_\_\_\_\_  
Phone: \_\_\_\_\_ Last Rabies Vaccine: \_\_\_\_\_  
Referring Doctor/Hospital: \_\_\_\_\_  
Referring Phone: \_\_\_\_\_ Referring Fax: \_\_\_\_\_  
Referring Email: \_\_\_\_\_ Preferred contact method: phone fax email

History/reason for referral:

Exam/diagnostic findings (please send if possible):

Chronic illnesses/medications/allergies:

Please Fax to (585)486-3127 or email [info@arkvh.com](mailto:info@arkvh.com).