Transfer Form

East Metro Animal Emergency Clinic

6225 Hwy 278 W/Covington, GA 30014
Phone: 678-212-0300
FAX: 678-212-0301

********Please fill out and send with client or fax this form to us when transferring a patient********

Client/ Veterinarian Information:

Referring Veterinarian or Clinic:_____ Date:_____
Client Name:_____ Pet Name: _____
Age:_____ Species:_____ Sex:_____ Spayed/Neutered:_____ Weight:_____

Medical Information:

Differential Diagnosis (or differential list):_____

_____

Brief History or Problem:_____

_____

_____

Pre-existing Problems (Blindness, chronic lameness, DM, etc.):_____

_____

Lab Results: FELV/FIV:_____ HW:_____ Fecal:_____ Other:_____
Radiology results (if digital please send a copy with the client):_____

_____

Desired TX plan:_____

_____

_____

Medications Administered:

1. Drug name:_____ Dose:_____ Route:_____ Time given:_____
2. Drug name:_____ Dose:_____ Route:_____ Time given:_____
3. Drug name:_____ Dose:_____ Route:_____ Time given:_____
4. Drug name:_____ Dose:_____ Route:_____ Time given:_____
5. Drug name:_____ Dose:_____ Route:_____ Time given:_____
6. Drug name:_____ Dose:_____ Route:_____ Time given:_____

Fluid Type:_____ Route:_____ Rate:_____ Volume Infused:_____ Additives:_____

Laboratory tests you would like Performed:_____

Additional info, history, or notes:_____

_____

_____

_____

_____

_____

_____

I (doctor) would like to be called at home in the event:_____
Phone Number (only if you would like to be called if above mentioned occurs):_____