



**WEARE ANIMAL HOSPITAL and
EXOTIC AND BIRD CLINIC OF NEW HAMPSHIRE
REFERRAL FORM**

Date: _____

Patient Being Referred To: *(please check the Service and state a reason if available)*

	Reason:
<input type="checkbox"/> General Practice	
<input type="checkbox"/> Behavior	
<input type="checkbox"/> Exotics	
<input type="checkbox"/> i-131	
<input type="checkbox"/> Ear Clinic	
<input type="checkbox"/> Stem Cell Therapy	

Referring Hospital: _____ Hospital Phone: _____

Hospital Fax: _____ Hospital E-Mail: _____

Referring Veterinarian: _____

Owner Name: _____ Patient Name: _____

Species: _____ Breed: _____ Age: _____ Sex: _____

Presenting Problem/Diagnosis:

Diagnostic Results:

Treatment/Medications:

Additional Comments:

Additional enclosures: **X-rays:** Yes / No **Blood work:** Yes / No

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Revised: September 10, 2008.. Please discard all previous forms.