



**Chicago
Veterinary Emergency
and Specialty Center**

CVES FAX: 773-281-7928

Referring Clinic: _____ Referring DVM Name: _____

Client Name: _____ Patient Name: _____

Species/Age/Breed/Sex/Spayed or Neutered: _____

Presenting Complaint/History: _____

Diagnostics Performed: _____

Important Findings: _____

Treatments Received: _____

Medication	Dosage/Route/Frequency	Next Dose Time	Comments

Will this patient need plasma or blood? YES / NO / Unknown

Other treatment/diagnostic requests: _____

_____ Please contact me prior to changing any of the plan above (i.e. medication, transfusion, etc.).

_____ Please call me with any changes to my patient's status.

After hours phone contact number _____

Name of CVES intake veterinarian (to be filled out by CVES): _____

Thank you for entrusting us with your patient's care!