

Animal Internal Medicine and Specialty Services & Animal Emergency Services



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≈Always Open≈

DATE:	REFERRING HOSPITAL:
REFERRING VETERINARIAN:	BEST CONTACT NUMBER FOR VET:
OWNER NAME:	PATIENT NAME: SPECIES:

PRESENTING PROBLEM AND PERTINENT DIAGNOSTICS: (please fax or attach diagnostics)

❖ **REFERRAL TO AIMSS SPECIALTY SERVICES:** (circle)

Internal Medicine Critical Care Oncology Surgery Other

❖ **REFERRAL TO ANIMAL EMERGENCY SERVICES:** (circle)

Regular Transfer Stable Observation Package (referring vet must call us first)

TREATMENTS STARTED:

IV FLUID TYPE:	FLUID RATE:	ADDITIVES:
DRUG:	DOSE:	TIME GIVEN:

WHEN SHOULD PATIENT RETURN TO YOUR HOSPITAL: (circle)

IN THE MORNING TRANSFER TO SPECIALTY SERVICES SEND HOME FROM AES IF
STABLE CALL REFERRING VET TO DISCUSS FIRST AT _____ PHONE NUMBER

OTHER:

❖ **OUTPATIENT ULTRASOUND:** (circle requested study)

ABDOMEN THORAX ECHO WITH CARDIO consult BICAVITARY U/S (abdo/thorax)

BICAVITARY U/S (ABDOMEN/ECHO WITH CARDIAC CONSULT)

OTHER:

IF LESION IS FOUND DO YOU WANT US TO OBTAIN TISSUE?

YES NO CALL REFERRING VET FIRST

IF LESION IS FOUND DO YOU WANT CLIENT TO HAVE CONSULTATION WITH ONE OF OUR

SPECIALISTS? YES NO CALL REFERRING VET FIRST