



Emergency #	Referral #
610-435-5588	610-435-1553
www.valleycentraler.com	

Client / Patient Transfer Form

Please Fax Prior To Transfer 610-435-6378

Referring Hospital Name: _____ Date: _____

Referring Veterinarian: _____ Phone: _____

Client Name: _____ Home Phone: _____

Address: _____

City/State/Zip _____

Pet's Name: _____ Dog _____ Cat _____ Other _____

Breed: _____ Sex: Male _____ Female _____ Intact Yes/No

Color: _____ Age: _____ Weight: _____ Date of last rabies vaccine: _____

Diagnosis or Clinical Condition: _____

Treatment Plan: _____

Current Medications: (including dosage and route of administration)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Time medication last administered:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Status of Patient At Time of Transfer: Critical/Stable

Temp _____ MM color _____ Resp rate _____ Heart rate _____

Past Medical History/Illness/Abnormalities we should be aware of: _____

Discharge to: Referring Veterinarian _____ Home _____ Valley Central Referral _____

Please Fax This Form Prior To Transfer – Include All Pertinent Information/Test Results/Radiographs
We are open at 6 pm weeknights and all day Friday, Saturday, Sunday and major Holidays