

EQUINE REFERRAL

Private Bag 11 222
Palmerston North 4442

Ph: (06) 350 5328

DATE: _____

REFERRING VETERINARIAN: _____

PRACTICE NAME: _____

Address: _____

Do you need to be consulted again before treatment at Massey? NO YES

- EMERGENCY MEDICAL
 NON-EMERGENCY SURGICAL
 LAMENESS
 NOT DETERMINED

Phone: _____ Fax: _____

Email: _____

Best time to reach me by phone: _____

OWNER'S DETAILS (If syndicate-owned, ONE owner's details must be listed)

Name: _____

Residential Address: _____

Postal Address (if different from above): _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Fax: _____

Email: _____

TRAINER'S DETAILS

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Fax: _____

PRIMARY CONTACT

Who will be primary contact for client communication? Owner Trainer

PATIENT DETAILS

Name: _____

Breed: _____

Colour: _____ Brand: _____

Age: _____ Sex: _____

TRANSPORT DETAILS

Method of Transport: _____

Transport Company: _____

Contact Phone Number: _____

E.T.A: known NO YES Time: _____

HISTORY & YOUR FINDINGS:

TREATMENT & RESPONSE:

REMARKS & SERVICE REQUESTED:

Invoice to go: Practice Other (Please specify) _____

Have you given client a cost estimate? NO YES Range \$: _____

PLEASE EMAIL THIS FORM PRIOR TO THE APPOINTMENT DATE TO: equinevets@massey.ac.nz

Replacement forms can be downloaded from our website: www.equinehospital.co.nz

Office use only:

Phoned: _____ Date & Time of Appointment: _____

Approximate Cost: _____ Confirmed By: _____ On Computer

