MANUKAU
after hours veterinary CLINIC

REFERRAL FOR OVERNIGHT CARE

CLIENT DETAILS

Name

Surname

Address

Phone home ( ) Work ( )

Mobile 1 ( ) Mobile 2 ( )

Email

PATIENT DETAILS

Patient Name

Species Age

Breed Weight

Date of Birth

Sex F ☐ M De-sexed? Y ☐ N ☐

History emailed ☐ Hard copy with client ☐

Monitoring Package: **Basic** ☐ **Comprehensive** ☐

REFERRING VETERINARIAN

Clinic Name

Name

Fluid Treatment Plan

Fluid Type (including additives)

Fluid Rate ml/hr

Fluids Provided: Yes ☐ No ☐

ADDITIONAL INFORMATION

Referral information: Emailed ☐ Faxed ☐ # of pages _____

Differential Diagnosis:

Primary reason for overnight care:

DRUG PLAN

Medication	Due	Provided: Yes ☐ No ☐
Medication	Due	Provided: Yes ☐ No ☐
Medication	Due	Provided: Yes ☐ No ☐
Medication	Due	Provided: Yes ☐ No ☐
Medication	Due	Provided: Yes ☐ No ☐
Medication	Due	Provided: Yes ☐ No ☐

Instructions if treatment plan requires change

- Call me to discuss ☐ Phone number: Latest time to ring
- Call client only ☐

COMMENTS