



**AVC**  
**ADVANCED VETERINARY CARE**  
**Patient Referral Form**

1021 East 3300 South  
 Salt Lake City, UT 84106  
 801-942-3951 • 801-485-2320 Fax

Client Name		DVM Name	
Patient Name		Hospital Name	
Client Phone		DVM Phone	
Lab Used		Lab Account #	

**Brief Case History**

*Please include all laboratory and other diagnostic reports. Radiographs will be promptly returned.*

**Referral Request**

As the referring veterinarian, my expectations for this case are as follows: (check one)

- 1. Referral for the following procedure(s): \_\_\_\_\_
- 2. Overnight care and return in the morning
- 3. Hospitalization for definitive care

**Important Note:** In recognition of changes in patient condition, doctor's evaluation and client wishes, AVC reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates.

**THANK YOU FOR YOUR REFERRAL. DIRECTIONS TO THE FACILITY ARE ON THE BACK OF THIS FORM.**

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