TrueCare for pets

The skill to heal. The spirit to care.

Date: ________ - ________ -20______

Direct Transfer Form

Transfer Information

Hospital

REFERRING HOSPITAL ____________________ REFERRING DR. ____________________

YOUR PHONE # FOR TONIGHT: ____________________ FOR 8:00 AM ____________________

Owner

LAST NAME ____________________ FIRST NAME ____________________

ADDRESS ____________________ CITY ____________________ ZIP __________

HOME PHONE ____________________ ALT. PHONE ____________________

Patient

PATIENT NAME ____________________ AGE __________

SPECIES: FELINE / CANINE / OTHER: ____________________ GENDER: MALE / FEMALE SPAYED / NEUTERED

BREED: ____________________ COLOR: ____________________ WEIGHT __________

WHO WILL PICK UP THE PATIENT IN THE MORNING? *CLIENT* *HOSPITAL*

Medical Information

IF THE SITUATION ARISES, SHOULD ATTEMPTS BE MADE TO RESUSCITATE?
(PLEASE ADVISE CLIENTS THAT CPR COSTS START AT $100)

YES (CPR) **NO (DNR)**

CASE HISTORY ____________________

____

____

PE FINDING / LAB RESULTS ____________________

____

____

____

AEC Treatments

FLUIDS

FLUID TYPE	ADDITIVES	RATE	BOLUS?	SENT

TREATMENTS / MEDICATIONS

DESCRIPTION	HOW OFTEN	STARTING	REFRIGERATE	SENT

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