Eastern Pennsylvania
Veterinary Medical Center
7042 Snowdrift Road
Suite 2
Allentown, Pennsylvania, 18106
Ph: 610-904-1776
Fax: 484-460-2646

Patient Referral Form

Date: _____

Referring Veterinarian Information:

Hospital Name: _____
Veterinarian Name: _____
Preferred Method of Contact:
☐ E-Mail _____
☐Phone _____
☐Fax _____

Patient Information
Patient Name: _____
Owner's Name: _____
Owner's Phone Number :_____

Primary Reason for Referral:

Brief History:

Previously Diagnosed Medical Conditions:

Current Medications (Times & Dosages):

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Please include medical records for your patient as well as all pertinent lab results, along with digital images of radiographic/ultrasound/CT/MRI studies.
Please send a long current oral or topical medication with the patient if possible.

Thank you for your referral, please do not hesitate to contact us with any questions prior to or following your patients visit.
Email Form to: Contact@epvmc.com
Fax Form to : 484-460-2646