MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
VETERINARY TEACHING HOSPITAL

Private Bag 11 222
Palmerston North 4442

Ph: (06) 350 5329
Fax: (06) 350 5747

Equine Referral

Date: _____

Referring Veterinarian: _____

Practice Name: _____

☐ **Emergency**

☐ **Non-Emergency**

☐ **Medical**
☐ **Surgical**
☐ **Lameness**
☐ **Not determined**

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

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

Best time to reach me by phone: _____

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

Surname: _____ First Name: _____

Residential Address: _____ Home Phone: _____ Work Phone: _____

_____ Mobile: _____

Postal Address (if different from above): _____ Fax: _____

_____ Email: _____

TRAINER'S DETAILS

Surname: _____ First Name: _____ Home Phone: _____

Address: _____ Work Phone: _____ Mobile: _____

_____ Email: _____ Fax: _____

PRIMARY CONTACT

Who will be primary contact for client communication? ☐ Owner ☐ Trainer

If "Other" please specify: _____

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: _____

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

PLEASE EMAIL THIS FORM PRIOR TO THE APPOINTMENT DATE TO equinefarmservices@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