

# EQUINE REFERRAL

Private Bag 11 222  
Palmerston North 4442

Ph: (06) 350 5328

DATE: \_\_\_\_\_

REFERRING VETERINARIAN: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

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

- EMERGENCY  MEDICAL  
 NON-EMERGENCY  SURGICAL  
 LAMENESS  
 NOT DETERMINED

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Best time to reach me by phone: \_\_\_\_\_

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

Name: \_\_\_\_\_

Residential Address: \_\_\_\_\_

\_\_\_\_\_

Postal Address (if different from above): \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## TRAINER'S DETAILS

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

## PRIMARY CONTACT

Who will be primary contact for client communication?  Owner  Trainer

## 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 (Please specify) \_\_\_\_\_

Have you given client a cost estimate?  NO  YES Range \$: \_\_\_\_\_

PLEASE EMAIL THIS FORM PRIOR TO THE APPOINTMENT DATE TO: [equinevets@massey.ac.nz](mailto:equinevets@massey.ac.nz)

Replacement forms can be downloaded from our website: [www.equinehospital.co.nz](http://www.equinehospital.co.nz)

### Office use only:

Phoned: \_\_\_\_\_ Date & Time of Appointment: \_\_\_\_\_

Approximate Cost: \_\_\_\_\_  Confirmed By: \_\_\_\_\_  On Computer

