

Central Hospital For Veterinary Medicine
4 Devine Street - North Haven, CT – 06473
Telephone: 203-865-0878 Fax: 203-867-5195



PATIENT TRANSFER SHEET

Your Hospital Name _____

Transferring DVM _____

Client Name _____

Patient Name _____ Canine ___ Feline ___ Spayed/Neutered _____

Gender ___ Age ___ Breed _____

Reason for Transfer

Current Medication

Name	Amount	Time Given

IV Fluids Administered

Type	Amount	Time

Radiographs Taken? Yes ___ No ___

Findings:

History (Please note any routine medication)

DVM to be contacted in case of questions _____ Telephone _____

Please fax along with any bloodwork and/or radiograph findings