NORTHEAST VETERINARY REFERRAL HOSPITAL

Internal Medicine Service
242 South River Street
Plains, PA 18705
Phone: 570-208-8844 Fax: 570-208-8855

Owner/Primary contact:

Last Name_____ First Name_____

Additional owner(s) _____

Address_____

City_____ ___State_____ Zip Code _____

Phones: Home_____Work#_____Cell#_____

Patient: Name_____ Species: Dog Cat Other

Breed:_____Color_____D.O.B./Age_____

Sex (please circle): Male Male Neutered Female Female Spayed

Referring Veterinarian's Name: _____

Referring Practice / Clinic :_____

Patient's regular Vet/Practice (if different from the referral):_____

Reason for today's visit:_____

_____

_____

• I (owner / agent) consent to medical evaluation and treatment provided by NVRH.

• I (owner / agent understand that fees are payable at the time services are rendered. NVRH does not have payment plan options available.

• I (owner / agent) understand that, if my pet is admitted to the hospital for a procedure, a deposit will be required. The balance will be due at the time of release / dismissal.

• We accept the following forms of payment: Cash, Check (with valid driver's license), Visa, MasterCard, Discover Card and Care Credit.

- CPR code status: _____CPR_____DNR (please initial)

Owner / Agent Signature_____ Date_____

Thank you for the opportunity to participate in your pet's health care. The veterinarian that referred you will receive a written summary of the care provided to your pet today.

NVRH

Committed to the future of advanced veterinary medicine in Northeast Pennsylvania ©