Morris Veterinary Cardiology

Nancy Morris DVM, DACVIM Cardiology Phone: 413-397-3271 Info@morrisvetcardiology.com

REFERRAL FORM for TECH VISIT FOR HOLTER OR ECG

NEW or EXISITING CLIENTS

Mobile Hospital Locations:

1. **Eastfield Hospital for Animials: 1964 Boston Rd, Wilbraham, MA 01095**
2. **Feeding Hills Veterinarian Clinic: 1194 Springfield Street, Feeding Hills, MA 01030**
3. **Northampton Veterinary Clinic: 190 Nootuck St. Suite 105, Northampton, MA 01062**

THIS FORM MUST BE FILLED OUT BEFORE YOUR CLIENT WILL BE CONTACTED TO SCHEDULE A MOBILE CONSULTATION. EMAIL THE COMPLETED FORMS TO INFO@MORRISVETCARDIOLOGY.COM. MORRIS VETERINARY CARDIOLOGY WILL PROCESS ALL REQUESTS FOR APPOINTMENTS AND PROVIDE THESE TO THE SPONSORING HOSPITAL WHO WILL IN TURN, CONTACT THE CLIENTS AND SCHEDULE APPOINTMENTS. CLIENTS SHOULD REACH OUT TO THEIR PRIMARY CARE VET FOR A REFERRAL FOR A MOBILE CARDIOLOGY CONSULTATION RATHER THAN CALL THE SPONSORING HOSPITALS DIRECTLY

Date of request:_____

Please check one of the following to indicate what procedure you are referring this patient for:

Recheck ECG on an existing patient ☐ Recheck Holter study on an existing patient ☐

New client/patient ECG ☐ New client patient Holter study ☐

Which location is closest to your client's home or which location should we schedule the client to for mobile cardiology consultations (check one):

Eastfield Hospital for Animals ☐

Feeding Hills Veterinarian Clinic ☐

Northampton Veterinary Clinic ☐

First Available: ☐

No Preference: ☐

What month are you seeking an appointment for? Click Here

Referring Veterinarian:

First Name: _____ Last Name:_____

Referring veterinary clinic or hospital: _____

Referring vet clinic or veterinarian email address:

_____

Phone:_____ **FAX**:_____

Client last name: _____ **First name**:_____

Client cell number:_____

Client Email Address: _____

Client home address (NEW CLIENT ONLY): _____

City:_____ **State:** _____ **Zip Code:** _____

Pet Name:_____ **Dog vs cat** Click Here **Sex:** Click Here **Age:**_____

Breed: _____

FILL OUT THE FOLLOWING SECTION FOR CURRENT OR EXHISTING CLIENTS/PATIENTS, ONLY:

1. **Date of last ECG or Holter study:** _____ **Previous diagnosis:**_____

2. Reason for recheck ECG or Holter study (check that apply):

☐ routine recommended recheck ☐ recheck ECG after beginning or changes to medications

☐ Arrhythmias have worsened via auscultation.

3. **Has the patient had an exam and echo study previously performed by Dr. Morris?**

☐ Yes *or* ☐ No *If yes, please provide date: _____

4. **New lab test results since the previous visit:**

☐ Yes *or* ☐ No

If yes list them and any abnormalities:

5. **Any new problems or diseases diagnosed since the previous visit:**

☐ Yes *or* ☐ No

If yes please list it here:

6. **List all current medications. If any changes to heart-related medications please briefly describe the reason for the change, previous dosage, new dosage, and approximate date of changes to the medications.**

7. **Any changes to clinical signs or status of the patient since the last visit?**

☐ Yes *or* ☐ No

If yes, describe:

8**. Any new chest radiographs or other imaging studies since the last cardiology visit?**

☐ Yes *or* ☐ No

If yes make sure to email a copy of your radiology viewer and radiology consultation report to: info@morrisvetcardiology.com.

_ FILL OUT THE FOLLOWING SECTIONS ONLY FOR NEW CLIENTS/PATIENTS:

1. **Current medical history/tentative diagnosis:**

2. **List concurrent medical problems:**

3. **Date of most recent lab results:**

Bun:_____Creatinine:_____SDMA:_____ Sodium:_____Potassium:_____T4 level:_____

If on a thyroid supplement date that last T4 level was rechecked: _____

Other lab abnormalities (please list here):

4. **Chest Radiographs in the most recent 6 months?**

☐ Yes or ☐ No

**If yes, these images must be emailed along with a radiology viewer and if radiology consultation was sought a copy of the report must be received prior to the scheduled consultation. Failure to submit radiographs in timely fashion can not only lead to an incorrect diagnosis, it can delay reporting and recommendations or initiation of treatment.*

5. **List all current medications.**

Does the patient normally receive or require anxiety medications or oral sedatives such as Gabapentin or Trazodone before office visits?

☐ Yes or ☐ No

If yes, list the dosage and timing of administration prior to visits:

6. **Has an ECG been performed or a telemedicine consultation about arrhythmias been performed?**

☐ Yes or ☐ No

*If yes please email a copy of the ECG recording or telemedicine report, prior to the scheduled visit.