East Pines
ANIMAL CLINIC
& REFERRAL SERVICES

Phone: 812-897-0810
Fax: 812-897-4139
Email: eastpinesanimalclinic@gmail.com

• 466 W SR 62 • Boonville, IN 47601 •
• www.eastpinesanimalclinic.com •

REFERRAL FORM

Date: _____

Please choose which department you are referring this patient:

☐ **Surgery**

Sara Mauck Burns, DVM, DACVS-SA
Board Certified Small Animal Surgeon
Email: eastpinesburns@gmail.com

Jeff Mauck, DVM
Email: jwmauck@mw.twcbc.com

☐ **Ophthalmology**

Breanna Brash, DVM, MS, DACVO
Board Certified Veterinary Ophthalmologist
Email: brash.breanna@gmail.com

Referring Veterinarian Information

Clinic Name: _____ Doctor: _____
Phone Number: _____ Fax Number: _____
Clinic/Doctor E-mail address: _____
How do you prefer to receive your patient's history? ☐ Fax ☐Email
Has a quote been given: ☐ Yes ☐ No Procedure Quoted: _____ Amount Quoted: $_____
Please check: ☐ Our client will be contacting your clinic ☐ Please contact our client for appointment

Client Information

Name: _____ Phone: _____
First Last Primary Secondary
Address: _____
Street City State Zip

Patient Information

Name: _____ Species: _____ Color: _____
Breed: _____ Sex: _____ Altered: Yes / No
Age: _____ Weight: _____ Temperament: _____

Patient History

Reason for Referral: _____
_____
_____

Radiographs Performed: ☐ No Images ☐ Sent w/Client ☐ Emailed
Date emailed: _____ Emailed To: ☐ Dr. Burns ☐ Dr. Mauck ☐ Dr. Brash ☐ Clinic
Date Radiographs Performed: _____ Body Part Radiographed: _____
Has pre-anesthetic bloodwork been performed? ☐ Yes ☐ No Date Performed: _____
Diagnostics Performed: (Please include a copy of all results with patient history)
_____
_____
Current Treatments/Medications: (Please include medications dosages and time last given)
_____
_____

Patient must be current on vaccinations when referred to East Pines Animal Clinic.
Vaccine Given: _____ Date Given: _____

Please Fax or Email Form and Patient History Including Vaccines & Recent Bloodwork