

**NEW HAVEN CENTRAL HOSPITAL FOR VETERINARY MEDICINE**  
**Internal Medicine**  
**Patient Referral Form**

*Please return to Dr. Harley at New Haven Central Hospital for Veterinary Medicine by e-mail, fax or US Mail. Send medical records and test results prior to the date of appointment. Include any radiographs labeled with clinic name and return address. Clients may call seven days a week to schedule a consult. Dr. Harley is available Monday through Thursday to discuss a potential referral or e-mail her directly anytime.*

**Leyenda Harley DVM**  
**Small Animal Internal Medicine**  
**New Haven Central Hospital for Veterinary Medicine, Inc.**  
**843 State Street**  
**New Haven, CT 06511**  
**Phone:(203) 865-0878**  
**Fax: (203) 867-5195**

Email: [iharley@centralpetvet.com](mailto:iharley@centralpetvet.com)

Date: \_\_\_\_\_

**Referring Veterinarian Information:**

Doctor's Name: \_\_\_\_\_ Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail: \_\_\_\_\_

How would you prefer to be contacted about this case?

Phone  Fax  E-mail

**Client Information:**

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

Phone: \_\_\_\_\_ E-mail \_\_\_\_\_

**Patient Information:**

Name \_\_\_\_\_ Species \_\_\_\_\_ Breed \_\_\_\_\_

Sex \_\_\_\_\_ Neutered: Yes  No  Age \_\_\_\_\_

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

Past relevant history:

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Medical treatments and current medications:

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Diagnostics already performed/pending:

Please list tests performed:

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Pending tests:

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Name of lab for pending tests: \_\_\_\_\_

How will medical records be sent?

Fax (preferred)  Email  Mailed  Client will bring

**Thank you for your referral!**