

**NEW HAVEN CENTRAL HOSPITAL
FOR VETERINARY MEDICINE**
843 State Street
New Haven, CT 06511
Tel: 203-865-0878 Fax: 203-867-5195

TRANSFER SHEET

Hospital Name: _____ Date: _____

Doctor Name: _____

Client Name: _____

Patient Name: _____ Canine: _____ Feline: _____ Spay/Neutered: _____

Gender: _____ Age: _____ Breed: _____

Reason for Admission: _____

Medication: _____ Amount _____ Time _____

Fluids Given: _____ Amount _____ Time _____

Radiographs Taken: Yes _____ No _____

Findings: _____

History (Please note any routine medications):

Doctor to be called tonight in case of a problem? Yes _____ No _____ Contact Tel # _____

***** Please fax and/or send blood work and radiographs *****
This document can also be found on our website at www.centralpetvet.com