



Inland Valley Veterinary Specialists

10 West 7th Street • Upland, California 91786

Phone 909-931-7871 • Fax 909-931-5383

www.ivsvets.com

CRITICAL CARE TRANSFER FORM

Referring Dr: _____ Referring Hospital: _____

rDVM Tel# tonight (optional) _____ Tel# for 8 am update: _____

Owner's Name: _____ Tel# _____ Cell# _____

Pet's Name: _____ Breed _____ Age _____ M F N Vaccines Current? Y N

Presenting Complaint/Tentative Diagnosis: _____

Other Pertinent Medical Conditions: _____

Items sent with patient: xrays records lab results fluids meds other _____

Already sent to lab: blood urine other: _____ Lab: Idexx Antech other _____

Treatments received already:

1. _____
2. _____
3. _____
4. _____
5. _____

CPR?

no code

yes, do CPR

OVERNIGHT TREATMENT PLAN: **IVVS DVM, please do the following:**

treat as noted below determine treatment plan Call rDVM before any changes? Y N _____

| A. Fluid Type | additives | | | | | | | | | | | | rate | | | | | | | | | | | | bolus? | | | | | | | | | | | |
|---------------------|-----------|-----|---|---|---|---|---|---|---|---|----|----|------|-----|---|---|---|---|---|---|---|---|----|----|--------|--|--|--|--|--|--|--|--|--|--|--|
| B. Treatments | 12n | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12m | 1am | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12n | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Diagnostic Tests | 12n | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12m | 1am | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12n | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Monitor/Other | 12n | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12m | 1am | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12n | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Referred for: Overnight Care Ongoing (24 Hour) Care U/S Xrays

Tomorrow morning: Transfer back to rDVM Call rDVM at _____ a.m. to discuss

Transfer to IVVS Surgery Dept. Transfer to _____

Pet will be picked up by: Client Technician rDVM Ambulance Other: _____

Expected time of pickup? _____



DIRECTIONS

Located on the Southwest corner of Euclid & 7th Street.

FROM 10 FWY WEST:

Exit Euclid Avenue and continue on 7th Street.

FROM 10 FWY EAST:

Exit Euclid Avenue and head North. Turn Left (West) on 7th Street.

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