CHARLESTON VETERINARY REFERRAL CENTER

3484 Shelby Ray Court
Charleston, SC 29414
Tel: 843.614.VETS(8387)
Fax:843.614.8722
Email: info@charlestonvrc.com
Web: www.charlestonvrc.com

Your Name _____ Spouse/Partner _____

Home Address _____Apt# _____

City _____State _____Zip _____

Home Phone _____ Mobile _____ Work _____

Other Phone _____ Fax _____ Email_____

How would you prefer to be contacted? Home _____Work ____Mobile _____Email_____

Employer _____ Occupation _____

If we are unable to reach you, who may we contact in case of emergency?

Name _____Phone _____

Do you authorize this person to make treatment decisions if you are not reachable? Yes ___No___

Please list people in addition to your primary care veterinarian to whom we may release information:

Name(s): _____ Phone_____

How did you hear about us? _____

Pet Information

Pet Name _____ Canine ____Feline_____ Other_____ Breed _____

Date of Birth _____ Color_____ Male ___Female ___Neutered/Spayed __Yes __No

Presenting Problem /Special Needs / Concerns: _____

_____

Primary Veterinarian(s) - (This is where we will fax your records)

Doctor's name: _____ **Hospital:** _____

By listing your primary care veterinarian above, you are authorizing our hospital to release patient information to the additional hospital or veterinarian(s) listed. **Are there any other veterinarians to whom you would like us to send updates or information? (If yes please list here)**

_____

I hereby authorize CVRC to render medical care for my pet(s) as deemed necessary by the veterinarian. I understand that no guarantee can be given to the outcome of treatments and take it as my responsibility to comprehend any risks involved.
I agree to pay for the cost of all services to which I consent to by written or verbal estimate. I understand that a deposit is required before diagnostics and treatments can be initiated and that payment in full is required prior to discharge of my pet from CVRC.

Preferred Payment Method: □ **Cash** □ **Check** □ **Credit/Debit Card** □ **Care Credit**

Signature _____ Date_____

Hospital Use only: Entered by: Initials _____ Date _____