



Ginger's Legacy

Referral Form

Mission Statement: We will prevent the financial burden of life saving medical care from ending a beloved pet's life prematurely by helping responsible pet owners meet the costs of unanticipated crucial pet treatments.

Referral Approved By:

Dr. _____ Date _____

Client _____

Address _____

Phone Home ____ - ____ - _____ Business ____ - ____ - _____

Referred By Dr. _____

Referring Clinic/Hospital _____

Address _____

Phone ____ - ____ - _____ Fax ____ - ____ - _____

Regular Veterinarian Dr. _____

Address _____

Phone ____ - ____ - _____ Fax ____ - ____ - _____

PatientName _____

Species _____ Breed _____ Age _____

Gender: Male _____ Neutered Male _____

Female _____ Spayed _____

Unknown _____

Reason for Referral _____

Tentative Diagnosis/Chief Complaint _____

History/Physical Findings _____

Laboratory Data (Attach Copy of All Results) _____

Radiographs (Films will be returned) _____

Treatments (Attach medical record) _____

Sent with Owner _____

Record Faxed _____

X- Rays Sent _____

For more information or if you have questions, please contact:
The Cartwright Foundation for the Care and Treatment of Sick or Injured Animals
5312 Piñon Dr. Elizabeth, CO 80107

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Web: gingerslegacy.com E-mail: gingerslegacy@aol.com