

## REFERRAL FORM

### EMERGENCY / IMAGING / SURGERY

Client name \_\_\_\_\_  
Client phone # \_\_\_\_\_  
Patient name \_\_\_\_\_  
Breed \_\_\_\_\_  
Patient age or D.O.B. \_\_\_\_\_  
Sex \_\_\_\_\_  
Date of last rabies vaccine \_\_\_\_\_  
Current Diet (if prescribed) \_\_\_\_\_

Prior health problems / Past pertinent history:

Current problem list / Reason for referral:

Diagnostics already performed (please check below and fax lab reports to 1-866-895-6030)

Radiographs \_\_\_ Bloodwork \_\_\_ Cytology/Histopathology \_\_\_  
Ultrasound \_\_\_ Urinalysis \_\_\_ Other (please specify) \_\_\_\_\_

Current treatment (including dosage):

Referring Veterinarian \_\_\_\_\_  
Referring Hospital \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-mail \_\_\_\_\_

If possible please fax the patient's medical records and all lab reports. Thank you.