VCA Canada Tri Lake
Animal Hospital & Referral Centre
Ph: 250.766.3236 **Fax:** 250.766.3237

OUTPATIENT CT REFERRAL

DATE: _____ mm/dd/year

PATIENT INFORMATION:

PET NAME: _____ DOB: _____ mm/dd/year

SPECIES/BREED: _____ COLOUR: _____

GENDER: ☐ M ☐ MN ☐ F ☐ FS

CLIENT INFORMATION:

NAME: _____

PHONE: (H) _____ (C) _____

EMAIL: _____

ADDRESS: _____

REFERRING HOSPITAL INFORMATION:

REFERRING HOSPITAL: _____

REFERRING DVM: _____

PHONE: _____ FAX: _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: ☐ Phone ☐ Email ☐ Fax

OUTPATIENT CT REQUESTED: ☐ CT ☐ CT with Contrast

Outpatient CTs will be booked based on next available appointment. If you would like the interpretation completed STAT please indicate here: ☐ STAT Read

REGIONS OF INTEREST: please specify desired site(s) for imaging

_____

_____

PRIMARY COMPLAINT: _____

_____

Please complete both pages of this form and return to: trilake@vca.com

VCA Canada Tri Lake
Animal Hospital & Referral Centre
Ph: 250.766.3236 **Fax:** 250.766.3237

OUTPATIENT CT REFERRAL

RELEVANT HISTORY / CLINICAL SIGNS: _____

_____

_____

_____

_____

_____

_____

COMPLETED DIAGNOSTICS: _____

_____

_____

_____

CURRENT TREATMENTS & MEDICATIONS: _____

_____

_____

_____

_____

DOCUMENTS INCLUDED:

- ☐ Medical records*
- ☐ Lab results*
- ☐ Radiographs

DOCUMENTS WILL BE SENT VIA:

- ☐ Email (preferred)
- ☐ Courier / Fax (circle)
- ☐ w/ Client
- ☐ PACS

***Outpatient CTs will be performed under sedation therefore medical records and current bloodwork is required. If bloodwork is not provided, we will run in-house prior to the CT.**

I consent to the use and storage of my information in accordance with the terms and conditions detailed in the VCA Canada Privacy Statement, a copy of which is available at vcacanada.ca/about/privacy-statement/

_____

Referring DVM Signature

Please complete both pages of this form and return to: trilake@vca.com