VCA Canada Tri Lake
Animal Hospital & Referral Centre

Ph: 250.766.3236 **Fax:** 250.766.3237

PATIENT REFERRAL FORM

DATE: _____

REFERRING HOSPITAL INFORMATION:

REFERRING HOSPITAL: _____

REFERRING DVM: _____

PHONE: _____ FAX: _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: ☐ Phone ☐ Fax ☐ Email

DEPARTMENT REFERRING TO:

- ☐ Rehabilitation & Pain Management
- ☐ Dermatology*
- ☐ Behaviour*
- ☐ ~~Surgery~~ (not currently available)
- ☐ Ultrasound**
- ☐ Endoscopy

Nutrition*

- ☐ Veterinarian Consultation (Vet to Vet communication only)
- ☐ Telemedicine Service (Communication with Client)

* The department to which you are referring has Supplemental Information forms, please consult the Referral Forms page on our website (vcacanada.com/trilake) or call the hospital (250-766-3236) to obtain service specific forms.

** This is an outpatient service and does not include client communication; the imaging report will be sent to the referring veterinarian to review with the client.

REASON FOR REFERRAL: _____

_____

PATIENT SHOULD BE SEEN:

☐ Next Available ☐ Urgent ☐ Emergency (please call)

Please call 250-766-3236 for ALL emergent cases

If you cannot be reached and there is a concern regarding the stability of the patient, do we have your consent to provide treatment by appropriate specialist if determined that the situation needs to be dealt with on an emergent basis or treatment by ER doctor until appropriate specialist is available?

☐ Yes ☐ No

If the service to which you have referred this case feels that your patient could benefit from an internal referral, can this occur without contacting you? ☐ Yes ☐ No

Please complete both pages of this form and email or fax to trilake@vca.com or 250.766.3237

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CLIENT INFORMATION:

NAME: _____

PHONE: (H) _____ (C) _____

EMAIL: _____

ADDRESS: _____

PATIENT INFORMATION:

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

SPECIES/BREED: _____ / _____

COLOUR: _____ GENDER: ☐ M ☐ MN ☐ F ☐ FS

BODY WEIGHT: _____ BODY CONDITION SCORE: _____

DATE OF LAST RABIES VACCINE: _____

PATIENT TEMPERAMENT:

Please advise if your patient is anxious ☐ Yes ☐ No

and if so, what pre-visit pharmaceuticals will you be providing to improve their experience with us:

_____

_____

FULL PATIENT RECORD:

Please email a complete copy of the patient's medical record including all completed blood work.

DOCUMENTS INCLUDED:

☐ Medical records

☐ Lab results

☐ Radiographs*

How many radiographs are you sending? _____

DOCUMENTS WILL BE SENT VIA:

☐ Email ☐ Fax

☐ with Client ☐ Other: _____

How many documents are you sending? _____

*Please send any radiographs as DICOMs -contact our Referral Coordinators for assistance.

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CURRENT/RELEVANT HISTORY: *Please highlight any medical alerts and drug reactions. To aid in the diagnostic yield, please include your clinical findings and impressions of the case, any recent laboratory tests, imaging findings etc.*

_____

_____

_____

_____

_____

CURRENT TREATMENTS & MEDICATIONS:

_____

_____

_____

PLEASE LIST ANY PREVIOUS CLINICS THE PATIENT HAS BEEN TO:

_____

_____

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