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24 Hour Emergency
 Anesthesia
 Cardiology
 Critical Care
 Diagnostic Imaging
 Medicine
 Neurology
 Oncology
 Surgery

REFERRAL REQUEST

Service Referring to: Critical Care Cardiology Medicine Neurology Oncology Surgery

1. REFERRING VETERINARIAN	Referring Veterinarian : _____ Clinic : _____ Phone : _____ Fax : _____ Email Address : _____						
2. CLIENT'S INFORMATION	Client's Name : _____ Street : _____ City : _____ Postal Code : _____ Phone : _____ Cell : _____ Email : _____						
3. PATIENT'S INFORMATION	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Patient's Name : _____</td> <td style="width: 50%;">Breed : _____</td> </tr> <tr> <td>Colour : _____</td> <td> Sex : <input type="checkbox"/> M <input type="checkbox"/> Spayed/Neutered <input type="checkbox"/> F <input type="checkbox"/> Intact </td> </tr> <tr> <td colspan="2" style="text-align: right;">Age : _____ yrs _____ mos</td> </tr> </table>	Patient's Name : _____	Breed : _____	Colour : _____	Sex : <input type="checkbox"/> M <input type="checkbox"/> Spayed/Neutered <input type="checkbox"/> F <input type="checkbox"/> Intact	Age : _____ yrs _____ mos	
Patient's Name : _____	Breed : _____						
Colour : _____	Sex : <input type="checkbox"/> M <input type="checkbox"/> Spayed/Neutered <input type="checkbox"/> F <input type="checkbox"/> Intact						
Age : _____ yrs _____ mos							
4. CHIEF COMPLAINT & HISTORY	_____ _____ _____ Duration : _____ days _____ months _____ years						
5. LABORATORY RESULTS	Pertinent Laboratory Results : _____ _____ _____ Laboratory Results Attached : <input type="checkbox"/> CBC <input type="checkbox"/> CHEM <input type="checkbox"/> U/A OTHER : _____						
6. CURRENT THERAPY & MEDICATIONS	_____ _____ _____						
7. RADIOGRAPHS	Radiology (Please list or state any rule outs or concerns you have) : _____ _____ _____ <input type="checkbox"/> FILM or <input type="checkbox"/> DIGITAL Radiographs <input type="checkbox"/> Sent with Client <input type="checkbox"/> Emailed <input type="checkbox"/> Timeless						
8. SIGNATURE	Signature : _____ Date : _____ x _____ / / _____						

Thank you for your Referral