



PATIENT REFERRAL FORM

Ph: 403.520.8387 Fax: 403.692.4350

REFERRING HOSPITAL INFORMATION: DATE: _____

REFERRING HOSPITAL: _____

REFERRING DVM(s): _____

HOSPITAL PHONE: _____ FAX: _____

HOSPITAL EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: Phone Email Fax

DEPARTMENT REFERRING TO: PREFERRED DR. (if any): _____

- Cardiology (call for dates) Dentistry/Oral Surgery Dermatology
- Emergency Internal Medicine Oncology
- Ophthalmology Neurology Surgery
- Ultrasound please specify cardiac abdominal

If the service to which you have referred this case at the C.A.R.E. Centre feels that your patient could benefit from an internal referral to another C.A.R.E. Centre service, can this occur without contacting you? Yes No

PATIENT SHOULD BE SEEN:

- next available appointment urgent emergency
please call

DOCUMENTS INCLUDED:

- Medical records
- Lab results
- Radiographs

DOCUMENTS WILL BE SENT VIA:

- Fax Email With client
- PACS Courier Other: _____

If you can not be reached and there is a concern regarding the stability of the patient:

- 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.
- Send patient back to primary care facility



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CLIENT INFORMATION:

NAME: _____
PHONE: (h) _____ (c) _____
EMAIL: _____
ADDRESS: _____

PATIENT INFORMATION:

PET NAME: _____ DOB: _____ m/d/year
SPECIES/BREED: _____ GENDER: [] M [] M(n) [] F [] F(s)

PRESENTING COMPLAINT: _____

CURRENT/RELEVANT HISTORY: Include behavioural concerns, medical alerts, history of seizures or drug reactions. To aid in the diagnostic yield, please provide your clinical findings and impressions of the case, any recent laboratory tests, imaging findings ETC.

Multiple horizontal lines for writing current/relevant history.

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 vccanada.ca/about/privacy-statement/

rDVM SIGNATURE _____