PATIENT REFERRAL FORM

VCA Canada Calgary Animal Referral & Emergency Centre

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: ______________________________

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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.*

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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/

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rDVM SIGNATURE

Please complete both pages of this form and fax to VCA Canada CARE Centre 403.692.4350