PATIENT REFERRAL FORM

VCA Canada Vancouver Animal Emergency & Referral Centre

Ph: 604.879.3737 **Fax:** 604.733.6340

REFERRING HOSPITAL INFORMATION: DATE: _____

REFERRING HOSPITAL: _____

REFERRING DVM: _____

HOSPITAL PHONE: _____ FAX: _____

HOSPITAL EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: ☐ Phone ☐ Email ☐ Fax

DEPARTMENT REFERRING TO:

- ☐ Emergency
- ☐ Ophthalmology
- ☐ Surgery
- ☐ Internal Medicine Consult
- ☐ Internal Medicine - Endoscopy
- ☐ Internal Medicine - Oncology
- ☐ Imaging ☐ CT ☐ MRI ☐ Xray ☐ Ultrasound

PREFERRED DR. (if any): _____

PATIENT SHOULD BE SEEN:

☐ next available appointment ☐ urgent ☐ emergency *please call VAERC*

DOCUMENTS INCLUDED:

- ☐ Medical records
- ☐ Lab results
- ☐ Radiographs

DOCUMENTS WILL BE SENT VIA:

☐ Fax ☐ Email ☐ With client

☐ PACS ☐ Courier ☐ Other:_____

REASON FOR REFERRAL: _____

_____

_____

Please complete both pages of this form and fax to VCA Canada Vancouver Emergency 604.733.6340

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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. Please attach/send all supporting documents.*

_____

_____

_____

_____

_____

_____

_____

CURRENT TREATMENTS & MEDICATIONS:

_____

_____

_____

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/

_____
rDVM SIGNATURE

Please complete both pages of this form and fax to VCA Canada Vancouver Emergency 604.733.6340