TORONTO VETERINARY EMERGENCY HOSPITAL
24 Hour Emergency & Referral Hospital

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24 Hour Emergency
Critical Care
Anesthesia
Diagnostic Imaing
Medicine
Neurology
Oncology
Surgery

# REFERRAL REQUEST

**Service Referring to :** ☑ ☐ Critical Care ☐ Diagnostic Imaging ☐ 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** | Patient's Name : | | Breed : |
| | Colour : | Sex : ☐ M ☐ Neutered ☐ F ☐ Intact | Age : _____ years _____ months |
| **4. CHIEF COMPLAINT & HISTORY** | | | |
| | Duration : _____ days _____ months _____ years | | |
| **5. LABORATORY RESULTS** | Pertinent Laboratory Results : | | |
| | Laboratory Results Attached : ☐ CBC ☐ CHEM ☐ U/A OTHER : _____ | | |
| **6. CURRENT THERAPY & MEDICATIONS** | | | |
| **7. RADIOGRAPHS** | Radiology (Please list or state any rule outs or concerns you have) : | | |
| | ☐ FILM Radiographs ☐ DIGITAL Radiographs ☐ Sent with Client ☐ Emailed ☐ Timeless | | |
| **8. SIGNATURE** | *Signature :* | | *Date :* |
| | × _____ | | _____/_____/_____ |

*Thank you for your Referral*