TORONTO VETERINARY EMERGENCY HOSPITAL
24 Hour Emergency & Referral Hospital

21 Rolark Drive Toronto, Ontario M1R 3B1
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24 Hour Emergency
Critical Care
Diagnostic Imaging
Medicine
Surgery
Rehabilitation
Cardiology
Neurology

REFERRAL REQUEST

Service Referring to: (please check) ☐ Critical Care ☐ Diagnostic Imaging ☐ Medicine ☐ Surgery ☐ Rehabilitation ☐ Cardiology ☐ Neurology

1. REFERRING VETERINARIAN

Referring Veterinarian:

Clinic:

Phone: Fax:

Email Address:

2. CLIENT'S INFORMATION

Client's Name: Patient's Name:

Street: City: Postal Code:

Phone: Cell: Email Address:

Breed: Colour: Sex: ☐ M ☐ F ☐ Neutered ☐ Intact Age: _____ years _____ months

3. CHIEF COMPLAINT/ HISTORY

Duration: _____ days _____ months _____ years

4. LABORATORY RESULTS

Pertinent Laboratory Results:

Laboratory Results Attached: CBC Chem U/A Other: _____

Current Therapy / Medication:

5. RADIOGRAPHS

Radiography (please list or state any rule outs or concerns you have):

Number of Radiographs Enclosed:

6. SIGNATURE

Signature:

✗ _____

Date (DD/MM/YYYY) ☐☐ ☐☐ ☐☐☐☐

Thank you for your referral