REFERRAL FORM

Please fax or email all laboratory work and relevant medical records

Client and Patient Information: **DATE:** ________________________

Client Name: ________________________________ PHONE: ___________________________________

Address: ____

PATIENT NAME: _______________________________ Breed: ____________________________________

Sex: F FS M MN Colour: ____________________ DOB: ________________________

Primary Veterinarian Information:

Primary Care Clinic: _________________________________ Veterinarian: __________________________

Phone: ____ Fax: _________________________________

REASON FOR REFERRAL:

- ◯ Orthopedic Surgery – Dr Audrey Remedios
- ◯ Abdominal Ultrasound
- ◯ Echocardiogram
- ◯ OTHER

DETAILS:

____

____

____

____

REFERRING VET: Does your client know that you are sending this referral? YES NO

*To ensure seamless service for your clients, we ask that you complete this form and send it along with relevant medical records, blood work and radiographs **prior** to your client calling to schedule an appointment.*

FAX: 403-678-3831 EMAIL: info@bowrivervetcentre.com Phone: 403-678-9595