Mississauga · Oakville
VETERINARY Emergency Hospital
Emergency & Referral Services

REFERRAL REQUEST

Date of Appointment: _____

Time of Appointment: _____

Doctor: _____

RDVM: _____ Hospital: _____

Phone: _____ Fax: _____ Email: _____

Client: _____ Phone: _____

Address: _____ City: _____

Postal Code: _____ Additional Phone #'s: _____

Patient: _____ Breed: _____

Age: _____ Sex: _____ Weight: _____

**** Please completely fill in client/patient information so records can be entered ahead of time ****

Summary of History and Physical Findings: **(Please DO NOT fax the complete medical record)**

Lab Tests: _____

Radiographs: _____

*** Please fax lab results with this form. Please send radiographs/scans and reports with patient ***

Current Medications: Current Diet:

Tentative Diagnosis:

Special Requests/Comments:

Please return referral request to reception@vetemergency.ca or fax to 905-829-9646

AAHA ACCREDITED