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 **MOVH@vca.com** or fax to **905-829-9646**

AAHA ACCREDITED