BOUNDARY BAY
VETERINARY SPECIALTY HOSPITAL

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REFERRAL REQUEST

DATE: _____/_____/_____

REFERRAL TO: ☐ Surgery ☐ Oncology ☐ CT ☐ Ultrasound ☐ Internal Medicine

TYPE: ☐ Urgent ☐ Next Available

REFERRING VETERINARIAN

Referring Hospital _____

Veterinarian _____

Daytime Phone _____ After Hours Phone _____

Email _____ Fax _____

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

CLIENT INFORMATION

First Name _____ Last Name _____

Street Address _____ City _____ Postal Code _____

Home Phone _____ Mobile Phone _____

Email _____

PATIENT INFORMATION

Name _____ Breed _____

Species _____ Birthdate _____/ _____/ _____

Sex ☐ M ☐ MN ☐ F ☐ FS Weight _____ ☐ lbs ☐ kg

REASON FOR REFERRAL *e.g. clinical history, PE findings, etc.*

DIAGNOSTICS & TREATMENTS *e.g. lab reports. etc.*

MEDICATION & DOSAGES

RELEVANT RECORDS

RECORDS SENT BY ☐ Fax ☐ Email ☐ Coming with owner