

**Referral for:**

- Emergency
- Surgery
- Neurology
- Internal Medicine
 - Endoscopy
 - Ultrasound

Client Information:

Date: _____

Last Name: _____ First Name: _____

Co-Owner Last Name (if different from above): _____ Co-Owner First Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____ HOME _____ WORK _____ CELL _____

E-mail: _____ Preferred Contact Method? Email Phone

Referring Veterinary Practice: _____ Referring Veterinarian: _____

Other Authorized Caregivers/Decision makers and contact info (incl. co-owner's contact numbers):

Patient Information:

Patient Name: _____ Age or date of birth: _____ Breed: _____

Colour & markings: _____ Sex: Male Female Intact Neutered

Last known weight: _____ Kilograms Pounds _____ Date of weight (if known): _____

Vaccines up to date? Yes No Heartworm Prevention? Yes No Product name: _____ Indoors only? Yes No

Reason for Referral / Clinical History *please send relevant history only; full medical history is generally not required

Treatment to Date*:

*For referral to Emergency Service; please include time, dose and frequency of medications and the date IV catheter was placed (Please note, all IV catheters will be assessed upon admission and replaced at our discretion).

Lab Reports and Images:

Lab Reports Emailed Faxed Sent with Client

Treatment Sheets Emailed Faxed Sent with Client

Radiographs Emailed Faxed Sent with Client

Clinical Images and Videos Emailed Faxed Sent with Client

Please email documents and images to frontdesk@londonregionalvet.com or fax to 519-432-0298

Other Information:

Thank You for referring this case to London Regional Veterinary Emergency and Referral Hospital

www.londonregionalvet.com