

REFERRAL FORM

West Coast Veterinary Dental Services

1350 Kootenay St, Vancouver, BC V5K 4R1

Phone: 604-473-3605 Fax: 604-473-3620



Today's Date: _____

Referral for: Consult/Procedure Yes No

Radiograph review: Yes No

CLIENT INFORMATION

Client Last Name:		Client First Name:	
Street Address:		City:	Postal Code:
Home Phone:	Work:	Cellular:	Email:

Has this patient/client been to our clinic before? Yes No

PATIENT INFORMATION

Name:	Species:	Breed:	Colour:
Sex: (M / MN / F / FS)	Date of Birth:		Age:

REFERRING CLINIC

Veterinary Hospital:	Work #
Veterinarian:	Fax #
Email:	

REFER TO: Please check all that apply: Dr. Loic Legendre Dr. Judy Rochette
 Dr. Adriana Regalado (Resident) Dr. Angie Bebel (Resident)

Does Dr. Nancy Brock need to be involved in this case: Yes No

Status: Emergency Urgent As Available

Radiographs(Dental) sent by: Owner Courier Email Not done

Reason for Referral and Patient History: (Please print/write legibly and use another page if needed)

QUESTIONS:

- Has recent blood work been done (last 6 months): Yes No Sent
- Have chest radiographs been obtained? Yes No Sent
- Has an Ultrasound/echo been performed? Yes No Sent
- Has the patient been diagnosed with any of the following? (please check all that apply)
 Heart Disease Liver Disease Seizure Disorders
 Kidney Disease Respiratory Disease Diabetes
- Has the patient shown any of the following clinical signs? (please check all that apply)
 Coughing Sneezing Vomiting
 Diarrhea Other

What medications is the patient currently on/has been dispensed: _____

Any other disease or illness, please describe and give details below: _____

