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 **OR** **Radiograph review:** ☐ Yes ☐ No

CLIENT INFORMATION

Client Last Name:	Client First Name:	
Street Address:	City:	Postal Code:
Primary Number:	Other:	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:

REFERRRING CLINIC

Veterinary Hospital:	Work #
Veterinarian:	Fax #
Email:	

REFER TO: Please check all that apply: ☐ Dr. Loic Legendre ☐ Dr. Angie Bebel ☐ Dr. Judy Rochette ☐ Dr. Adriana Regalado (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
  (We require blood work on pets 6 years and older)
- Have chest radiographs been obtained? ☐ Yes ☐ No ☐ Sent
  (We require rads on pets 10 years and older)
- 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: _____

_____
_____

*Please attach the last 2 years of the patients medical record. Appointments will be made once the full medical record has been received.

This referral has been reviewed by:
Doctors Signature _____