

**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:	

**REFERRING CLINIC**

Veterinary Hospital:	Work #
Veterinarian:	Fax #
Email:	

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

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 \_\_\_\_\_**