Small Animal
PATIENT REFERRAL

24 HOUR ANIMAL CARE CENTRE
1846 Victoria Avenue East, Regina S4N 7K3
Ph: (306) 761-1449 Fax: (306) 789-5535

Date: _____

VETERINARIAN information:

Clinic Name _____ Is this the client's regular clinic? ☐ Yes ☐ No

Referring DVM _____ Desired appt: Date _____ Time _____

OWNER information:

Owner's Name _____

Address _____ City _____ P. Code _____

Phone _____ Cell _____ Other _____

PATIENT information:

Patient's Name _____

Species _____ Breed _____ Description _____

Birth Date (MO/DAY/YR) _____ ☐ M ☐ F ☐ MN ☐ FS

Reason for Referral _____

Dx/DDX _____

_____

History/GPE_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Lab Data ☐ enclosed ☐ with owner ☐ previously sent

Imaging ☐ enclosed ☐ with owner ☐ previously sent

CURRENT THERAPY/MEDICATION/ALERTS (Please include all meds – chronic, OTC, supplements, etc., as well as any allergies/reactions. These are important details that could affect treatment)

_____

_____

_____

_____

Special Requests _____

or comments _____