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 Type: Emergent/Urgent/Non-Urgent

Are you referring for: diagnostics/monitoring only -OR- for our veterinarians to take over the case

REASON for Referral _____

OWNER information:

Owner's Name _____ Email _____

Address _____ City _____ Postal Code _____

Phone _____ Cell _____ Other _____

PATIENT information:

Patient's Name _____

Species _____ Breed _____ Color _____

Birth Date (MM/DD/YR) _____ Sex: M/F/MN/FS

Vaccinations UTD (Rabies and DHP/FVR): Yes/No

Dx/DDX _____

_____

History/GPE_____

_____

_____

_____

_____

_____

_____

_____

Cardiac Normal/Abnormal **Neurologic** Normal/Abnormal

Respiratory Normal/Abnormal **Urinary/Renal** Normal/Abnormal

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)

_____

_____

_____

RDVM Wishes:

- If we find something on diagnostics do you wish for us to discuss and make recommendations to the client based on our findings? Yes/No.
- Do you wish to leave a contact number in case we need to contact you with any questions/concerns outside of regular business hours? Yes/No If yes, please list _____

Thank you for your referral. We look forward to working with you. A copy of all diagnostics and/or exam notes will be forwarded to you within 24 hours of discharge (or sooner). If at any point you have questions regarding the referral process, or about a patient that is in our care, please feel free to contact a supervisor at any point (available until 11pm daily).