

Please fax completed form to 506-854-6077

REFERRING VETERINARIAN INFORMATION

Referring Veterinarian:	Telephone:
Veterinary Hospital:	Fax:
Preferred contact method: <input type="checkbox"/> Fax <input type="checkbox"/> Telephone <input type="checkbox"/> Email	Email:

CLIENT INFORMATION	PATIENT INFORMATION
Client Name:	Pet Name:
Address:	Species: Canine <input type="checkbox"/> Feline <input type="checkbox"/> Other <input type="checkbox"/> Breed: _____
Home Telephone:	Age: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>
Work Telephone:	Neutered? Yes <input type="checkbox"/> No <input type="checkbox"/>
Cellular Telephone:	Current Weight: _____ kg/lbs

Patient History (please include clinical signs and abnormal examination findings): _____

Diagnostics/Blood Tests performed (please attach results, send radiographs with owner or email electronic radiographs): _____

Tentative Diagnosis: _____

Current Medication/Dosage: _____

Special Instructions/Comments: _____

Referring Veterinarian's signature _____ Date _____