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Phone: 506-854-6257
Fax: 506-854-6077
Website: www.oaksvet.ca

Please fax completed form to 506-854-6077

REFERRING VETERINARIAN INFORMATION

Referring Veterinarian:	Telephone:
Veterinary Hospital:	Fax:
Preferred contact method: Fax Telephone Email	Email:

CLIENT INFORMATION	PATIENT INFORMATION
Client Name:	Pet Name:
Address:	Species: Canine ___ Feline ___ Other ___ Breed: _____
Home Telephone:	Age: _____ Male ___ Female ___
Work Telephone:	Neutered? Yes ___ No ___
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 _____