VETDERM
ALLERGY, EARS, & SKIN SPECIALISTS

Patient Referral Form

Date of Referral _____

OWNER INFORMATION:

Owner Name(s) _____

Primary Phone Number _____ Alternate Phone Number _____

Contact E-mail _____

Address _____ City _____ Postal Code _____

PATIENT INFORMATION:

Patient Name_____ Breed_____ Sex _____

Date of Birth_____ Temperament _____

Vaccination Status_____ Anesthetic Risk _____

REFERRING VETERINARIAN INFORMATION:

Doctor Name_____ Clinic Name _____

Phone Number _____ Fax Number _____

Contact E-mail _____

Desired Method of Referral Report Delivery: ❑ Fax ❑ Email

STATUS OF REFERRAL ❑Non-urgent ❑ Urgent ❑ Emergency

Desired Location of Consultation:
❑In House (Client consult & Patient evaluation at referring clinic)
❑Vancouver Satellite (Intercity Animal Emergency Clinic)
❑Coquitlam Satellite (Central Animal Emergency Clinic)
❑Victoria Satellite (Downtown Veterinary Clinic)

Reason for Patient Referral (Case Summary):

healing is a team effort

t. 604 564 2214
f. 604 564 2215
e. info@vetdermclinic.com
w. vetdermclinic.com

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Diagnostics, Treatments and Response to therapy:

(Please attach any diagnostic or laboratory reports)

Other Systemic/Non-Dermatologic Disease:

Special Requests or Expectations:

Thank you for your referral.
We appreciate your time and effort in filling out this information.
Your client will be contacted shortly to schedule an appointment.

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