SHAW PET HOSPITALS

Phone: 250-652-4312 FAX: 250-652-4338

DATE OF REFERRAL ____

CLIENT AND PATIENT INFORMATION

CLIENT NAME:______________________________ PATIENT:______________________________

CLIENT PHONE: H)______________________________ W)______________________________

SPECIES:______________ BREED:________________ AGE:_______ FI FS MI MN

VETERINARIAN INFORMATION

REFERRING HOSPITAL:____

VETERINARIAN:______________________________ DAYTIME PHONE: ______________________

AFTER HOURS PHONE:______________________

- Surgery
- Ultrasound
- Endoscopy
- Digital Radiography
- 24 Hour Critical Care
- Other (please specify) ______________

Nuclear Medicine (I-131): please see specific referal form for I131 patients.

REQUEST: ☐ NEXT AVAILABLE APPOINTMENT ☐ URGENT ☐ EMERGENCY

CLINICAL SIGNS AND HISTORY:

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Please provide current treatments with dates, times and doses. Relevant records and laboratory results should be faxed. If you have scheduled the appointment for your client, please list date ______________________ and time ______________.

ADDITIONAL CLIENT COMMUNICATION:____

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RADIOGRAPHS ARE ☐ COMING WITH THE OWNER ☐ BEING SENT BY COURIER ☐ NOT DONE

DERMATOLOGY REFERRAL FORM IS ☐ COMING WITH THE OWNER ☐ BEING SENT BY MAIL OR FAX