

BLUEWATER VETERINARY EMERGENCY CLINIC **REFERRAL FORM**

IF YOU ARE TRANSFERRING A PATIENT TO THE BLUEWATER EMERGENCY VETERINARY CLINIC PLEASE FILL OUT THIS FORM PRIOR TO TRANSFER.

DATE: _____

EXPECTED TIME OF ARRIVAL (if applicable): _____

PATIENT INFORMATION:

PET NAME:

SPECIES:

BREED:

AGE:

LAST RECORDED WEIGHT (KG):

GENDER (PLEASE CIRCLE):

M | MN | F | FS | UNKNOWN

ALERTS OR COMMENTS (Pre-existing conditions, dog aggressive, nervous, allergies, raw diet, etc.)

VACCINE STATUS (please list current vaccinations):

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VETERINARY EMERGENCY CLINIC

CLIENT INFORMATION:

CLIENT NAME (first and last):

CLIENT EMAIL:

CLIENT PRIMARY PHONE:

CLIENT SECONDARY PHONE:

ADDRESS:

REFERRING CLINIC INFORMATION:

REFERRING CLINIC NAME:

DVM NAME:

rDVM PHONE:

rDVM EMAIL:

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VETERINARY EMERGENCY CLINIC

CASE INFORMATION:

PRESENTING COMPLAINT/WORKING DIAGNOSIS:

MOST RECENT PHYSICAL EXAMINATION FINDINGS:

DIAGNOSTICS COMPLETED (*please email all diagnostic results (Bloodwork, radiographs, ultrasound results, etc.) to info@bluewatervec.ca*)

TREATMENTS AND MEDICATIONS (*please specify doses and time last administered*):

HAVE COST EXPECTATIONS BEEN COMMUNICATED TO THE CLIENT? IF SO, PLEASE INFORM BELOW:

PLEASE EMAIL ALL PATIENT HISTORY AND RECORDS TO INFO@BLUEWATERVEC.CA

PLEASE NOTE THAT IF HOSPITALIZATION IS STILL REQUIRED AT THE TIME OF BVEC CLOSING, THE CASE WILL BE TRANSFERRED TO THE MOST APPROPRIATE REFERRAL/EMERGENCY HOSPITAL OR BE TRANSFERRED BACK TO REFERRING CLINIC IF WARRANTED.