Referral Service Request Form

Fax to: 03-5481712

Referral to the Halifax Veterinary Centre For: (please tick appropriate service)

☐ Phone Consultation ☐ Surgery ☐ Medicine ☐ Diagnostic imaging

☐ Radiological Interpretation ☐ Animal Behaviour ☐ Ophthalmology ☐ Dermatology

Client Details:

Client Name ____

Address ____

Town / City ____

Telephone (Hm) ______________ Work ______________ Mobile ______________

Patient Details:

Name__________________ Species ______________ D.O.B ______________

Sex: F / FS / M / MC Breed ______________________________

Vaccinations Status Current: ☐ Yes ☐ No Vaccine(s) Used ______________

Referring Veterinarian Details:

Referring Veterinarian ____

Practice ____

Address ____

Telephone ______________________ Fax ______________________

E-mail ____

Office Use Only:

Appointment with: Dr. ______________________

Date: ______________________

Time: ______________________

Please use the reverse side to give a detailed case review / description.

Case History Details

Presenting complaint(s)

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Initial Diagnostic Test(s) Performed (please tick box and append copies to be faxed / sent)

☐ CBC	☐ Biochemistry	☐ Urinalysis	☐ Urine culture
☐ Cytology	☐ X-rays	☐ Coagulation test	☐ Cultures

Other tests (please specify)

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Treatment(s) given

Drug ______________________ Dose and duration ______________________

Drug ______________________ Dose and duration ______________________

Drug ______________________ Dose and duration ______________________

Drug ______________________ Dose and duration ______________________

Additional treatment / therapy

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Reason(s) for referral

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