Thunder Bay Veterinary Hospital

Small Animal Referral Information Form©

Your patronage is very important to us. All clients will be advised to return to their primary care veterinarian for all other health matters.

Date: _____

Primary Care Veterinarian: _____
Referral Clinic/Hospital: _____
Referral Clinic/Hospital Fax: _____
Referral Veterinarian Preferred Contact
Phone Number: _____

Client Name: _____
Home Phone: _____
Cell Phone: _____
Address: _____
_____
Email Address: _____

Patient Information:

Name: _____ Breed: _____ Age: Y___MO____ M ☐ F ☐ Neutered/Spayed ☐

Request Service:

□ Ultrasound
□ Pain Relief
□ Laparoscopy (Biopsy, Gastropexy, Ovariectomy)
□ Orthopedic Surgery (TTA, External and Internal Fixation)
□ Rhinoscopy / Cystoscopy
□ Endoscopy (Upper/Lower GI)
□ Otoscopy
□ Other

Presenting Complaint:

How may we help you and your patient:

Relevant Medical History and Ongoing medications:

***Please send digital images in DICOM format, diagnostic results, and all medical records along with this referral.**

Would you prefer to contact the owner directly after the procedure? YES NO

Have you faxed or emailed recent relevant medical history and radiographs to TBVH? YES NO

We strive to give the primary care veterinarian a call on the same day of the procedure and have a written report faxed to your practice within 48 hours of the procedure. We welcome an open case discussion and observation of the procedure to all referring Veterinarians. Clients are encouraged not to observe procedures. Please inform your clients to contact TBVH to book the appointment. TBVH currently does not employ board certified specialist veterinarians.

For Office Use Only:
Initials: _____ Referral form received by
Initials: _____ Referral flag placed in file
Initials: _____ Form-record-X-rays received
Initials: _____ Referral vet contacted
Initials: _____ Appointment booked
Initials: _____ Referral report/summary sent

EMAIL TO: reception@tbvet.com

Thank you very much for allowing us to assist with your patient care!

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