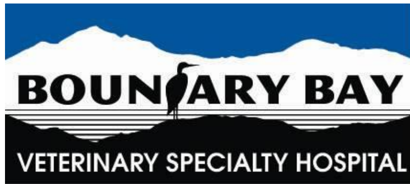

ONCOLOGY REFERRAL REQUEST

Dr. Sarah Charney

ORF1

Do not write in this area

Referring Hospital	DATE
Referring Veterinarian (print)	***Referring Veterinarian Phone #*** ☆ ☆

CLIENT

Client Last Name		First Name
Street Address	City	Postal Code
Home Phone	Cellular	★Email

PATIENT

Name	Breed	Species	Sex M MN F FS	Age (MM / DD / YYY)

REASON FOR REFERRAL

Current Concern(s) Requiring Referral

Has a biopsy or cytology been performed (not required) If so, what were the results?
If possible, please attach results to this request.

Past Procedures Performed. (Radiographs, Ultrasound, Diagnostic Tests) *Please send radiographs with client or download digital radiographs directly.*

Current Treatment/Medications currently or previously given.

Appointment Date	Appointment Time	Booked By	
Appointment Reminder done on	Date	Time	BBVSH staff

Once you have faxed your referral, please contact our office to confirm receipt.

Phone 604-514-8383 Fax 604-514-1712