BOUNDARY BAY
VETERINARY SPECIALTY HOSPITAL

INTERNAL MEDICINE REFERRAL REQUEST

Dr. Astrid Nielssen

IMR5

Do not write in this area

Referring Hospital	DATE
Referring Veterinarian (print)	***Referring Vet Phone Number*** ☆ ☆

IT IS IMPERATIVE THAT A COMPLETE MEDICAL RECORD IS RECEIVED AT LEAST 24HRS PRIOR TO APPOINTMENT. RECORD MAY BE SENT BY MAIL, FAX OR EMAIL. INCLUDE RADIOGRAPHS, ULTRASOUND REPORTS ETC. DICOM RADIOGRAPHS AND ULTRASOUNDS MAY BE DIRECTLY DOWNLOADED (CALL FOR INFO).

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 / YYYY)
CURRENT MEDICAL CONCERN(S) REQUIRING REFERRAL 1. 3. 2. 4.				
RELEVANT HISTORY, COMMENTS OR SPECIAL CONCERNS				

PROCEDURES PERFORMED
(Radiographs, Ultrasound, Diagnostic Tests, Previous Consults

Medications / OTC / Supplements

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

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

Phone 604-514-1711 Fax 604-514-1712