SURGERY REFERRAL REQUEST

BOUNDARY BAY VETERINARY SPECIALTY HOSPITAL

SRF3

Do not write in this area

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

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

Relevant History, Comments, Special Concerns

Past Procedures Performed. (Radiographs, Ultrasound, Diagnostic Tests)

Please send radiographs with client or download digital radiographs directly.

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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