Referral and Emergency Transfer Form

Alta Vista ANIMAL HOSPITAL

Date of appointment: .....

Referring Clinic: .....

Referring Veterinarian: .....

Email address: .....

Referral to:

- ☐ Dentistry
- ☐ Internal Medicine
- ☐ Specialty Surgery
- ☐ Cardiology
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Dermatology
- ☐ Emergency/ICU

Client Information

Name: .....

Phone #: .....

Address: .....

Patient Information

Name: .....

Species/Breed: .....

DOB: ..... Colour: .....

Sex: ..... Weight (kg): .....

Included/Relevant Documents:

- ☐ Medical records
- ☐ Blood work
- ☐ Radiographs
- ☐ Other .....

Sent by:

- ☐ Fax: (613)731-2315
- ☐ Email
  - ☐ Eyes@avah.on.ca
  - ☐ oncology@avah.on.ca
  - ☐ InternalMedicine@avah.on.ca
  - ☐ dentistry@avah.on.ca
  - ☐ specialtysurgery@avah.on.ca
  - ☐ dermatology@avah.on.ca
  - ☐ emergency@avah.on.ca

Presenting Complaint: .....

Current/Relevant History:

Current Treatments & Medications

To ensure optimal patient care, please be sure to speak with an Emergency DVM prior to any EMERGENCY transfer

We would like to be able to keep you updated on your patients, therefore please provide your preferred method of communication

☐ Phone _____ ☐ Fax _____ ☐ Email _____