Small Animal Referral Service

Mark E.H. Smith Inc

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Diplomate, American College of Veterinary Surgeons

Date of referral: _____

Client & Patient Information (if you have a label, please place here):

Client Name: _____ Patient Name: _____

Client phone H) _____ W)_____

Species: _____ Breed:_____ Age/DOB:_____ FI FS MI MN

Veterinarian Information:

Referring Hospital: _____ Veterinarian: _____

Phone: _____ After-hours phone: _____

Fax: _____ Email: _____

Request for Service at:

☐ Aldergrove Animal Hospital
tel: 604-856-7707
fax: 604-856-1255
email: wecare@aldergrovevet.com

☐ Canada West Veterinary Specialists
tel: 604-473-4882
fax: 604-473-4898
website: www.canadawestvets.com

☐ Chase River Veterinary Hospital, Nanaimo
tel: 250-591-4050
fax: 250-591-4054
email: info@chaserivervet.ca

☐ Granville Island Veterinary Hospital
tel: 604-734-7744
fax:604-733-0412
email info@bcpetvet.com

☐ Scottsdale Veterinary Hospital
tel: 604-590-2121
fax: 604-590-0293
email scovethosp@telus.net

Priority: ☐ Next available ☐ Urgent

Reason for Referral: _____

History: _____

_____

Clinical Signs: _____

_____

Relevant Clinical Pathology data: _____

Current Treatments: _____

Radiographs: ☐ not done ☐ coming with owner ☐ emailed

Special Requests: _____

We prefer reports by: ☐ Fax ☐ Email