



Patient Referral Form

Date of Referral _____

OWNER INFORMATION:

Owner Name(s) _____

Primary Phone Number _____ Alternate Phone Number _____

Contact E-mail _____

Address _____ City _____ Postal Code _____

REFERRING VETERINARIAN INFORMATION:

Doctor Name _____ Clinic Name _____

Phone Number _____ Fax Number _____

Contact E-mail _____

Desired Method of Referral Report Delivery: Fax Email

STATUS OF REFERRAL Non-urgent Urgent Emergency

LOCATION FOR DERMATOLOGY CONSULT: Vancouver Surrey No preference

PATIENT INFORMATION:

Patient Name _____ Species _____

Breed _____ Sex _____

Date of Birth _____ Vaccination Status _____

Anesthetic Risk _____ Cardiac status _____

Heart Murmur / Grade 1 2 3 4 5 6 None

Non-dermatological conditions / disease _____

Temperament _____

FAS Score 0 Relaxed 1 Mild 2-3 Moderate 4 Severe (flight, freeze, fret) 5 Severe (fight/aggression)

Is anti anxiety medication needed or been prescribed for veterinary visits? _____

**Please note, pre-visit pharmaceuticals including Gabapentin and Trazodone, do not interfere with dermatology assessment or allergy testing. If the patient requires anti anxiety medication for examination, please provide to client prior to the initial consultation.*



Primary Reason for Patient Referral:

Case Summary:

Medications / Treatments and Response to therapy:

Diagnostics (Please attach any diagnostic or laboratory reports):

Special Requests or Expectations:

**Thank you for your referral.
We appreciate your time and effort in filling out this information.
Your client will be contacted shortly to schedule an appointment.**

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healing is a team effort