

**Is this a Referral to
Emergency Service?**
(If yes please check)



Today's Date: _____

www.westernvet.ca
1802 - 10th Ave S.W. Calgary, AB T3C 0J8
Phone: (403) 770-1340 Toll Free: 1-866-770-1340
Fax: (403)770-1344; referral@westernvet.ca

Appointment

Date: _____

Time: _____

Attention Service:

*Please check box below

Anesthesiology

Matt Read
DVM, MVEtSc
Diplomate American College of
Veterinary Anesthesiologists

Internal Medicine

Sheri Clarkson
BSc, DVM
Diplomate American College of
Veterinary Internal Medicine

Debby Henderson
DVM
Internal Medicine

Oncology

Neal Mauldin
DVM
Diplomate American College of
Veterinary Internal Medicine
Diplomate American College of
Veterinary Internal Medicine
(Oncology)
Veterinary Radiology (Radiation Oncology)

Glenna Mauldin
DVM, MS
Diplomate American College of
Veterinary Internal Medicine
(Oncology)
Diplomate American College of Veterinary

Ophthalmology

Cheryl Cullen
DVM, MVEtSc
Diplomate American College of
Veterinary Ophthalmologists

**Rehabilitation Therapy
& Acupuncture**

Veronica Devall
DVM, CCRT, CVA, VSMT

Surgery

Dave Fowler
DVM, MVEtSc
Diplomate American College of
Veterinary Surgeons

Audrey Remedios
DVM, MVEtSc
Diplomate American College of
Veterinary Surgeons

Dave Szentimrey
DVM, MVEtSc
Diplomate American College of
Veterinary Surgeons

Patient Referral Form (available online at www.westernvet.ca)

Owner Information: Client Name: _____

Primary Phone: () _____ Additional: () _____

Patient Information: Patient Name: _____ Breed: _____

Sex: F FS M MN Date of Birth: _____ Weight: _____ kg

Referring Veterinarian Information: Hospital Name: _____

Veterinarian: _____ Phone: () _____

Fax: () _____ Email: _____

Other veterinarians involved in this case: _____

(Please check off on the left the service you are referring your patient to)

Please indicate how you are sending the following:	Email or Online	Fax	With Owner	Courier
Referral Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relevant Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

History and Physical Finding: _____

Has the client been given an estimated fee for services? YES _____ NO _____

If so, how much was quoted? _____