RIVERVIEW ANIMAL HOSPITAL
24 Hour Emergency Care

PATIENT REFERRAL FORM

550 Pine Glen Rd
Riverview, NB E1B 4X2
506-387-4015 fax: 387-7656
info@riverviewah.ca

Referral Veterinarian Information:

Veterinarian_____Hospital_____

Phone _____ Cell Phone _____

Email Address _____

Best time to Contact you _____

Patient Information:

Client's Name_____

Phone number_____

Patient's Name_____Species_____Breed:_____

Birthdate _____ Colour_____ Sex (Spayed/Neutered)_____

Reason for Referral:

Overnight Hospitalization/Critical Care ☐ Case Management to Conclusion ☐

_____

_____

Condition of Patient Healthy ☐ Stable ☐ Critical ☐

Pertinent Medical History (Including Current Diagnostics/Treatments/Medications)

AAHA ACCREDITED The Standard of Veterinary Excellence

REFERRAL INSTRUCTIONS: When referring your patient to RAH, please complete this form and forward it as well as all pertinent medical records and fax to 387-7656 or email to info@riverviewah.ca Along with above information please ensure that you contact the Dr. that will be managing the case at RAH to ensure continuity of care.