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## Patient Referral Form

### Referral Veterinarian Information

Veterinarian: \_\_\_\_\_ Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best Time to Contact You: \_\_\_\_\_

Dr. Contacted for Referral: \_\_\_\_\_

### 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)



**REFERRAL INSTRUCTIONS:** When referring your patient to RAH, please complete this form and forward it along with all pertinent medical records and fax to 506.387.7656 or send an email to [info@riverviewah.ca](mailto:info@riverviewah.ca). In addition to the above, please ensure that you contact the Dr. that will be managing the case at RAH to ensure continuity of care.