EVERGREEN VETERINARY DENTISTRY SERVICES REFERRAL FORM

735 Goldstream Avenue, Suite 133

Victoria, BC. V9B 2X4

Phone: (778) 601-3898 Fax: (778) 601-3897

Email: referrals@evds.ca

Today's Date (MM/DD/YY):

STATUS: Emergency ☐ Urgent ☐ As Available ☐

CLIENT INFORMATION:

Client Name:

Spouse/Partner/Alternate: Alternate/Spouse Number:

Street Address:

City: Province: Postal Code:

Mobile Phone Number: Landline or Other:

Email:

PATIENT INFORMATION:

Name: Species: Colour:

Breed: Weight (in kgs):

Sex: M ☐ MN ☐ F ☐ FS ☐

Date of Birth (MM/DD/YY): Age:

Is this pet insured? YES ☐ NO ☐ If yes, please note Company and #:

Is this patient a CAUTION? YES ☐ NO ☐

BITES ☐ SCRATCHES ☐ UNPREDICATBLE ☐ MUZZLE ☐

Is this patient a Certified Service Dog (sight, mobility, seizure/diabetic detection, PTSD etc.) or working dog (police/military/protection)? YES ☐ NO ☐

- If Yes: What function does patient perform?

Is this patient a breeding or show dog/cat? YES ☐ NO ☐

REFERRING CLINIC:

Veterinary Clinic Name:

Veterinarian:

Work #: Fax #:

Email:

Reason for Referral and Patient History (Please include client expectation ie. Root Canal, Extraction, etc.):

DIAGNOSTICS:

- Bloodwork within the last 3 months (we require blood work on pets 6 years and older prior to surgery):

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

  Abnormal Results?

- Have chest radiographs been obtained? (We require rads on pets 10 years and older or with changing heart disease/pulmonary hypertension)

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

- Has an Ultrasound/Echo been performed?

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

- Has the patient been diagnosed with any of the following? Please check all that apply:

  Heart Disease ☐ Liver Disease ☐ Seizure Disorders ☐ Thyroid Disease ☐

  Kidney Disease ☐ Respiratory Disease ☐ Diabetes ☐

- Date of last COHAT Procedure (MM/DD/YY):
- Photos attached? YES ☐ NO ☐

What Medication(s) is the patient currently on/have been dispensed:

Please attach **only the last 2 years** of patient medical record **(INCLUDING ALL DIAGNOSTICS)**. We will contact your client to schedule an appointment/procedure once the full medical record has been received.

Doctor Signature: