

Shuswap Veterinary Clinic
1050 4 Ave SW, Salmon Arm, BC V1E 4P2
Tel: 250-832-6069 Fax: 250-832-8154
Email: reception@shuswapvet.com
www.shuswapvet.com



Orthopedic Patient Referral Form

Today's Date: _____

Referring Veterinarian Information

Practice Name: _____ Veterinarian: _____

Phone #: _____ Fax #: _____

Email: _____ Preferred method of communication: Phone Email Fax

Client Information

Name: _____

Phone # Home: _____

Cell: _____

Other: _____

Address: _____

Patient Information

Name: _____

Species: _____

Breed: _____

Gender: FS MN F M

Date of Birth/Age: _____

Weight: _____

Reason for Referral /Case Summary:

If applicable please include the following when you send in your referral:

- | | |
|--|--|
| <input type="checkbox"/> Patient history/findings | <input type="checkbox"/> Previous Bloodwork |
| <input type="checkbox"/> Any Radiographic findings | <input type="checkbox"/> Any Pertinent Medical Records |

Where would you prefer to provide follow up care:

- At Shuswap Veterinary Clinic At your clinic To be determined

Please return referral request to reception@shuswapvet.com or fax to 250-832-8154