GOLDEN HORSESHOE
VETERINARY
SURGERY

TEL: 905 805-7796
FAX: 905 698-1256
EMAIL: sswayne@ghvetsurgery.com

SURGICAL REFERRAL REQUEST FORM

This form is to be completed and submitted by the primary care veterinarian.

Referring Veterinarian: Date:

Referring Clinic:

Clinic Phone Number: Clinic Fax Number:

Clinic email address:

Client Name: Client Phone Number:

Pet's Name: Breed: Age: Sex: M F MN FS

Presenting Complaint:

History:

Last Blood Work:

Abnormalities:

Current Therapy/Medication:

Other Health Concerns:

Laboratory Data Included: Yes ☐ No ☐

Radiographs: Digital Yes ☐ No ☐ If yes: emailed? Yes ☐ No ☐

Films Yes ☐ No ☐ If yes: sent with owner? Yes ☐ No ☐