Referral Form

Date: ___ /___ /____ Or:
DD MMM YEAR DROP DOWN CALENDAR

pulse
Veterinary Specialists & Emergency
Phone: 780-570-9999 Fax: 780-570-1149
450 Ordze Road, Unit #320. Sherwood Park, AB T8B 0C5
www.pulseveterinary.ca

Department Referring to:

Cardiology ☐ Cardiology: (ambulatory consult/echo request) ☐

Dentistry/Oral Surgery ☐ Diagnostic Imaging: outpatient (stable) ultrasound ☐

Emergency ☐ Internal Medicine ☐ Neurology ☐ Ophthalmology ☐ Surgery ☐

Preferred Doctor (if applicable): _____

Consent to perform an internal referral without contacting you? Yes ☐ No ☐

Patient to be seen: Next avail. appointment ☐ Next 24 hours ☐ Emergency (please call) ☐

Referring Hospital Information:

Referring hospital name: _____ Primary care DVM name: _____

Hospital phone: _____ Hospital fax: _____ Hospital E-mail: _____

Preferred method of communication: phone ☐ fax ☐ E-mail ☐

Client Information

Client name: _____ Spouse name: _____ Client phone: _____

Back-up phone: _____ Client E-mail: _____ Client Postal Code: _____

Client address: _____ City/province: _____

Patient Information

Patient name: _____ Date of birth (or age): _____

Species: _____ Breed: _____ Colour: _____

Sex: M☐ MN☐ F☐ FS ☐ Unknown☐ Weight: _____

Documents to be sent:

- ☐ Medical records:
- ☐ Lab results:
- ☐ Radiographs:
- ☐ Dental radiographs:
- ☐ Other: _____

Documents sent via:

- ☐ E-mail
- ☐ Fax:
- ☐ Sent with client
- ☐ Other: _____

Please submit this referral form (2 pages) by e-mail (referrals@pulseveterinary.ca) or fax (780-570-1149).
Our team will contact the owner to schedule a referral

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Presenting complaint or tentative diagnosis:

Relevant history and physical examination findings:

Important diagnostics findings:

Treatments and medications (dose, frequency, last dose):

Requests/comments:

By submission of this document, you are giving Pulse Veterinary Specialists & Emergency consent to use and store the information contained within this form

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