

850 Portland Street  
Dartmouth NS  
B2W 2N3  
Ph. (902) 435-2444 Fax. (902) 462-5285

## Referral form for:

(Please check appropriate box)

Laparoscopy

Endoscopy

Other \_\_\_\_\_

Appointment Date:

Time:

***APPOINTMENTS MUST BE ARRANGED IN ADVANCE BY REFERRING HOSPITAL***

***Please fax this form in advance to avoid delays upon admission.***

Referring Veterinarian:	Client: <span style="float: right;">Affix client label</span>
Hospital Name:	Address:
E-mail:	
Telephone:      Fax No.	Telephone:
Animal Name: <span style="float: right;">Affix patient label</span>	Other:
Breed    /    D.O.B    /    Sex    /    Colour	

**Date and type of last vaccination:**

**History/Physical Findings:**

**EKG/Radiographic Findings:** (Please send radiographs with patient or email to doctor)

**Current Therapy/Medication:**

**Tentative Diagnosis:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_

Signature

**Please inform clients their pet will need to be shaved and *possibly* given a sedative prior to ultrasound.  
All patients require fasting from 12a.m.**