



VETERINARY REFERRAL FORM

Please complete the following and return by fax or email:

Client first & last name: _____

Client contact phone number(s): _____

Client Email Address: _____

Client Home Address: _____ **City:** _____

Patient name: _____

Species: Dog or Cat **Breed:** _____

Is the patient up to date on their rabies vaccine (circle)? Yes / No **Colour:** _____

Sex (circle): Male/Female **and** Neutered/Spayed **Age (or date of birth):** _____

Please indicate the primary reason for referral (eg post-surgical rehabilitation, weight loss, sport dog or geriatric conditioning): _____

Does your clinic recommend muzzling the patient for handling or procedures

Please attach all relevant medical history and radiographs.

As the referring veterinarian, I understand that I remain the primary care provider.

DVM Signature

Printed/typed name of DVM

Date

Clinic name: _____

Clinic phone number: _____

Gilmour Road Veterinary Services
4424 Victoria Rd S, RR#1
Puslinch, ON, N0B2J0
P: 519-763-7729
F: 866-235-9691
guelphcompanionanimalrehab.ca
gilmour.road.vet@gmail.com