



**VETERINARY  
EMERGENCY  
CLINIC**

**Veterinary Emergency Clinic / Referral Centre**  
920 Yonge St. Suite 117, Toronto ON M4W 3C7  
Phone: (416) 920-2002 Fax: (416) 920- 6185  
E-Mail to: [referralform@vectoronto.com](mailto:referralform@vectoronto.com)  
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## **REQUEST FOR INTERNAL MEDICINE REFERRAL**

Dawn Martin, DVM DVSc Diplomate ACVIM (Internal Medicine)

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

Referring Clinic: \_\_\_\_\_

Clinic Phone Number: \_\_\_\_\_ Clinic Fax Number: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client Phone Number: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Presenting Complaint:

\_\_\_\_\_

\_\_\_\_\_

Synopsis of the patient medical history:

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Current Medications: \_\_\_\_\_

Laboratory Data Included:            Yes                            No

Radiographs Included                Yes                            No