



Veterinary Emergency Clinic / Referral Centre
920 Yonge St. Suite 117, Toronto ON M4W 3C7
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E-Mail to: referralform@vectoronto.com
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REQUEST FOR SURGICAL REFERRAL

Craig W. Miller DVM, MVSc, Diplomate ACVS
Devon Boyd DVM, Diplomate ACVS
Brendon Ringwood DVM, MS, Diplomate ACVS

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:

History:

Last Blood Work Done: _____

Current Therapy/Medication:

Other Health Concerns: _____

Laboratory Data Included: Yes No

Radiographs Included Yes No