



COLLINGWOOD

Animal Referral + Emergency Centre

Imaging REFERRAL FORM

Referring Veterinary Clinic Information

Clinic Name:	Fax:
Address:	Email:
Phone:	Referring Veterinarian:

Owner and Patient Information

Owner's Name:	Breed:	Sex:	☐ M	☐ F
Patient Name:	Age:	Weight:	kg	
Address:				
Phone:	Email:			
Species:	Neutered/Spayed:	☐ Yes	☐ No	
Up to date on Rabies:	☐ Yes	☐ No	Date of Last Administration:	

Clinical History and Reason for Referral

Presenting Complaint:
Duration of Problem:
Summary of Clinical History:

CARECOLLINGWOOD.VET

Contact

contact@carecollingwood.vet
Phone: 705-881-2273 (CARE)
Fax: 705-881-7883

Address

100 Pretty River Pkwy S #105,
Collingwood, ON L9Y 5A4



Clinical History and Reason for Referral Cont'd

Previous Treatments/Medications (include dosages & dates):

Laboratory/Imaging Results Attached: ☐ Yes ☐ No

Radiographs Attached: ☐ Yes ☐ No

Other Relevant Records Attached: ☐ Yes ☐ No

Referral Request: CT ☐ X-ray ☐ Ultrasound ☐

Additional Notes:

Signature of Referring Veterinarian:

Signed:

Date:

*PLEASE SEND RECORDS AND DIAGNOSTICS ALONG WITH REFERRAL FORM