



COLLINGWOOD

Animal Referral + Emergency Centre

Internal Medicine 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

Previous Treatments/Medications (include dosages & dates):

Previous Diet Trials:

Current Diet:

Laboratory/Imaging Results Attached: ☐ Yes ☐ No

Radiographs Attached: ☐ Yes ☐ No

Other Relevant Records Attached: ☐ Yes ☐ No

Additional Notes:

Signature of Referring Veterinarian:

Signed:

Date:

*PLEASE SEND RECORDS AND DIAGNOSTICS ALONG WITH REFERRAL FORM

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