



**Veterinary Specialty Centre  
Of Newfoundland and Labrador**

860 Topsail Road  
Mount Pearl, NL, A1N 3J7  
Appointments: 709 221 7838  
After Hours: 709 764 7888  
Web site: [www.VSCNL.ca](http://www.VSCNL.ca)

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\*\*\*Please Indicate if referring for [ ] Surgery and/or [ ] Radiology

**REFERRING VETERINARIAN:**

DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Check if any of this data is new since your last referral:

Practice Name: \_\_\_\_\_ PRACTICE'S E-MAIL: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

Check your preferred method of communication. E-mail  Fax  Phone

Have you provided an estimate for this client? Yes No if yes, what was the estimate? \_\_\_\_\_

**OWNER:**

Name: \_\_\_\_\_ Alternate Contact: \_\_\_\_\_

Last

First

Last

First

Address: \_\_\_\_\_

Street

City

Prov

Postal Code

Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_ @ \_\_\_\_\_

**PATIENT:**

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: M MN F FS Unknown Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Color(s): \_\_\_\_\_

**PRIMARY VETERINARY CARE PROVIDER**, if different from referring veterinarian identified above:

Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Chief Concern/Provisional Diagnosis: \_\_\_\_\_

\*History/Physical Findings: \_\_\_\_\_

Laboratory Data: (Summarize or attach photocopies of your reports) \_\_\_\_\_

Radiology: Radiographs Enclosed  Please return films  \_\_\_\_\_

Current Therapy & Medication: \_\_\_\_\_

\*Special Requests/Comments: \_\_\_\_\_

Has this patient cultured positive for MRSP? Yes No If Yes what was the sensitivity? \_\_\_\_\_

(\*There is additional space for your comments in each category on the BACK of this form.) \_\_\_\_\_

\_\_\_\_\_  
Signature of Referring Veterinarian

**REFERRAL REQUEST & INFORMATION**

# REFERRAL REQUEST & INFORMATION

(\* continued....)

\*History/Physical Findings:

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\*Laboratory Data:

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\*Radiology:

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\*Current Therapy & Medication:

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\*Special Requests/Comments: :

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ADDITIONAL INFORMATION: