

# Veterinary Emergency Clinic and Referral Centre

920 Yonge St. Suite 117, Toronto, ON M4W 3C7

Tel.: (416) 920-2002 Fax: (416) 920-6185

[www.vectoronto.com](http://www.vectoronto.com)

Dermatology email : [derm@vectoronto.com](mailto:derm@vectoronto.com)

## DERMATOLOGY REFERRAL QUESTIONNAIRE

Dermatologists:

Stephen Waisglass, B.Sc., D.V.M., CertSAD, Diplomate, American College of Veterinary Dermatology  
Karri Beck BSc, DVM, Diplomate, American College of Veterinary Dermatology

### SECTION B: TO BE COMPLETED BY THE REFERRING VETERINARIAN:

Section B must be returned to our hospital at least 1 WEEK prior to the appointment. Completed forms can be sent by E-mail: [derm@vectoronto.com](mailto:derm@vectoronto.com) or faxed to 416- 920-6185

Dear Doctor,

Thanks so much for taking the time to fill out the questionnaire. Visit to visit details are not required. **Please DO NOT SENT ENTIRE ELECTRONIC OR SCANNED RECORDS as a substitute for the forms**; electronic records often contain personal communications that are not relevant to the dermatology visit, as well as unrelated procedures in such volume that they can obscure relevant data. We know your time is valuable. **A very brief summary is all that is needed so that we can avoid drug reactions and duplication of treatment or procedures whenever possible.** We will be sure to contact you if we need clarification. A written report will be emailed following the visit. Please do not hesitate to call should you have any questions or concerns

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

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

Phone number: \_\_\_\_\_

Email (for visit summary): \_\_\_\_\_

Owner's Name (as per clinic records): \_\_\_\_\_

Pet's Name: \_\_\_\_\_

Pet's weight: \_\_\_\_\_ **KILOGRAMS**  
▽ (type in box or click on button for options)

Sex: \_\_\_\_\_ (neutered? intact?)

Birthdate (as per vet records): \_\_\_\_\_ MM/DD/YYYY

Breed: \_\_\_\_\_

If we feel that the patient may benefit from an internal consult, may we do so without contacting you?

NO YES

## SUMMARIZED VETERINARY HISTORY:

**PLEASE DO NOT SEND FULL COMPUTER HISTORY AND RECORDS AS A SUBSTITUTE FOR FILLING OUT FORMS** IN ORDER TO MAINTAIN CLIENT CONFIDENTIALITY; ELECTRONIC RECORDS OFTEN CONTAIN PERSONAL COMMUNICATIONS NOT RELEVANT TO THE DERMATOLOGY VISIT, AS WELL AS UNRELATED PROCEDURES AND DISCUSSIONS THAT COULD OBSCURE RELEVANT DATA. **A very brief summary is all that is needed so that we can avoid drug reactions and duplication of treatment or procedures whenever possible**

### RELEVANT MEDICAL HISTORY

DOES THE PET HAVE ANY RELEVANT NON- DERMATOLOGICAL DISEASE? ARE THERE ANY ANTIBIOTIC OR ANESTHETIC SENSITIVITIES? IF SO, PLEASE DESCRIBE:

### SUMMARIZED DERMATOLOGICAL HISTORY

IS THE PET ON HEARTWORM OR FLEA PREVENTION?

**NO**

**YES**

IF YES, WHICH? \_\_\_\_\_

**SUMMARIZED THERAPEUTIC HISTORY**

**(I.E. PREVIOUS TREATMENTS AND DIETS FOR THIS CONDITION HAVE INCLUDED THE FOLOWING):**

**DIAGNOSTIC TESTS:**

PLEASE SEND ALONG COPIES OF ANY PERTINENT DIAGNOSTIC TESTS (INCLUDING BLOOD TESTS AND FULL PATHOLOGY RESULTS). OTHERWISE, PLEASE LIST ANY DIAGNOSTIC TESTS PERFORMED, WITH DATE RUN AND FULL RESULTS. THANK YOU!

**NO TESTS PERFORMED**

**WILL SEND TEST RESULTS BY EMAIL TO [DERM@VECTORONTO.COM](mailto:DERM@VECTORONTO.COM) OR FAX TO:  
(416) 920-6185**

**SEE TESTS AS LISTED BELOW:**

ANY SUGGESTIONS, CONCERNS OR COMMENTS?