Veterinary Emergency Clinic / Referral Centre
920 Yonge St. Suite 117, Toronto ON M4W 3C7
Phone: (416) 920-2002 Fax: (416) 920- 6185
Email: info@vectoronto.com
Web: www.vectoronto.com

REQUEST FOR OPHTHALMOLOGY REFERRAL

Dr. Heather Gray DVM, Diplomate AVCO

Referring Veterinarian:_____

Referring Clinic: _____

Clinic Phone Number: _____**Clinic Fax Number:** _____

Client Name: _____**Client Phone Number:** _____

Pet's Name: _____**Breed:** _____**Age:**_____ **Sex: M** ◯ **F** ◯

Presenting Complaint: _____

Case urgency (check one)**:**
- ◯ **EMERGENCY (same day/soonest i.e. ruptured/melting cornea/acute glaucoma)**
- ◯ **URGENT (same/next day/soonest i.e. deep ulcer/severe uveitis/sudden blindness)**
- ◯ **PRESSING (within next 2 weeks i.e. superficial/indolent ulcer, painful eye)**
- ◯ **NONURGENT (routine next available i.e. cherry eye/lid mass/entropion/nonpainful)**

History (eye):

_____
_____
_____
_____
_____

Last Blood Work Done (Summarize AND include copies of all lab work):

_____
_____
_____
_____

Current Therapy/Medication (Detailed i.e. name, frequency, and duration):

_____
_____
_____
_____
_____

Other Health Concerns/History (Summarize)

_____
_____
_____
_____
_____

Laboratory Data Included: YES ◯ **NO** ◯
Medical Record Included: YES ◯ **NO** ◯