VETERINARY EMERGENCY CLINIC
920 Yonge Street, #117
Toronto, ON M4W 3C7
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REQUEST FOR SURGICAL REFERRAL

Brendon Ringwood DVM, MS, Diplomate ACVS
Whitney DeGroot DVM, Diplomate ACVS
Achilles Tang BVMS

Referring Veterinarian: _____ **Date:** _____

Referring Clinic: _____

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

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

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

Presenting Complaint:

_____
_____
_____

History:

_____
_____
_____

Last Blood Work Done:_____

Current Therapy/Medication:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Health Concerns: _____

Laboratory Data Included: Yes ◯ No ◯

Radiographs Included Yes ◯ No ◯

Email form to: info@vectoronto.com