



## REQUEST FOR OPHTHALMOLOGY REFERRAL

Dr. Heather Gray DVM, Diplomate ACVO

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 (select one):

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 <u>Included</u> :	YES	NO
Medical Record <u>Included</u> :	YES	NO

\*\*If this case is an emergency please call the clinic at (416) 920-2002 to speak to a member of our client services team.

**Email form to: [info@vectoronto.com](mailto:info@vectoronto.com)**