VETERINARY EMERGENCY CLINIC
920 Yonge Street, #117
Toronto, ON M4W 3C7
Phone: (416) 920-2002
Fax: (416) 920-6185
www.VECtoronto.com

REQUEST FOR OPHTHALMOLOGY REFERRAL

Dr. Heather Gray DVM, Diplomate ACVO | Dr. Shayna Levitt DVM, Diplomate ACVO

6-Apr-2026
Date

Requested Dr: ◯ Dr. Heather Gray ◯ Dr. Shayna Levitt ◯ No Preference/next available

Referring Veterinarian:_____

Referring Clinic: _____

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

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

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

Temperment:_____ ***If the patient requires sedation for examination please dispense for client prior to appointment.*

Presenting Complaint:_____

Case urgency (select one):

◯ **EMERGENCY (same day/soonest i.e. ruptured/melting cornea/acute glaucoma)**
***If this case is an emergency please call the clinic at (416) 920-2002 to speak to a member of our client services team.*

◯ **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 ◯

Email form to: info@vectoronto.com