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REQUEST FOR OPHTHALMOLOGY REFERRAL

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

ENTER 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