Lakeview
ANIMAL HOSPITAL

Lakeview Animal Hospital Rehabilitation

Referral Form

Please fax to: 1-888-371-3926 OR email to: contact@lakeviewanimalvet.com

Referring Veterinarian Information

Name of Practice: _____

Name of Veterinarian: _____

Phone: _____ Fax: _____

Owner Information:

Name: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell: _____

Patient Information

Name: _____ Species: _____ Breed: _____

Color: _____ Age: _____ Sex: _____ Weight: _____

Neutered/Spayed?: _____ Vaccine Status: _____

Current Diet: _____

4351 Savaryn Drive SW
Edmonton, AB T6X 2E8
Canada

Tel.: . 587.463.9002
Fax.: 1.888.371.3926
email: contact@lakeviewanimalvet.com
www.lakeviewanimalvet.com

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Medical History

Date of Injury/Surgery: _____

Presenting Complaint:

_____

_____

_____

Other Ailments or Medical Conditions:

_____

_____

_____

Allergies: _____

Diagnostic Results

All patients should have up to date diagnostics performed prior to their initial consultation

Blood Work:

_____

_____

_____

Radiographs:

_____

_____

_____

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Ultrasound:

_____

_____

_____

Other:

_____

_____

_____

Goal(s):

_____

_____

_____

Current Medications/Supplements

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

_____ _____

Signature of Referring Veterinarian Date

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