OKANAGAN VETERINARY HOSPITAL

Orthopedic Referral Information

Date:

Patient/Client Information

Owner:_____

Address:_____

Postal Code:_____

Phone:_____ Cell:_____

Email:_____

Pet name:_____Species:_____

DOB:_____Sex:

Behavior/Temperament:_____

Breed:_____ _Wt:_____

Referring Veterinarian Information

Hospital Name:_____

Veterinarian:_____

Phone:_____Fax:_____

Email:_____
(please indicate preferred contact method)

Status:
Urgent □ Non Urgent □ Emergency □

Limb(s):
RF □ **LF** □ **RH** □ **LH** □

Core Vaccine Status: (DA2PP and Rabies)
Current □ Unknown □

History
(please include presenting complaints, previous and current medical therapies and duration of problem)

Bloodwork (Please attach) Yes □ No □
Radiographs (JPEG Please attach) Yes □ No □

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