Central Toronto Veterinary Referral Clinic
CTVRC

1051 Eglinton Ave West
Toronto, ON M6C 2C9
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REQUEST FOR SURGICAL REFERRAL

Devon Boyd, DVM Diplomate ACVS (Surgery)

Referring Veterinarian: _____ Date: _____

Referring Clinic: _____

Clinic Phone Number:_____ Clinic Fax Number: _____

Client Name: _____

Client Phone Number(s): _____ _____

Client Email Address:_____

Pet's Name:_____ Species: _____ Colour: _____

Breed: _____ Age: _____ Sex: M ☐ F☐ Spayed/Neutered: Y☐ N☐

Presenting Complaint: _____

Synopsis of the patient medical history:

_____

_____

_____

_____

_____

_____

_____

Current Medications: _____

Allergies/Drug Reactions: _____

Laboratory Data Included: Yes ☐ No ☐

Radiographs: Emailed ☐ Sent with owner ☐ No Radiographs ☐