Phone: (204)452-0911

Fax: (204)269-9031

Info@BridgwaterVetHospital.ca

100-350 North Town Road R3Y 0Y4

**Orthopedic Referral Form**

**Referring Clinic Information**

Date of Referral:

Referring Clinic: Bridgwater Referring DVM:

Clinic Phone Number: Clinic Fax Number:

Clinic Email:

**Client Information**

Client Name(s):

Primary Phone Number: Additional Phone Numbers:

Client Address: Postal Code:

Client Email:

**Patient Information**

Patient Name: Patient Species:

Patient Breed: Patient Weight:

Patient Age: Patient Sex:

Patient Notes (i.e. Caution):

**History**

Reason for Referral and Patient History:

Previous Medical Concerns:

**History**

Current Medications:

**History**

**Questions – If Yes, Please Email to Info@BridgwaterVetHospital.ca**

Has the patient had recent (last 6 months) blood work performed:

Has the patient had chest radiographs performed:

Has the patient had an ultrasound/echo performed:

Has the patient been diagnosed with any of the following – Heart Disease, Liver Disease, Seizure Disorders, Kidney Disease, Respiratory Disease, Diabetes. If so, which:

Has the patient shown any of the following clinic signs – Coughing, Sneezing, Vomiting, Diarrhea. If so, which

Does this patient have any pre-existing conditions?

Special Requests and Additional Comments:

**Please email all medical records including radiographs to** **Info@BridgwaterVetHospital.ca****. Records must be received prior to the patient’s appointment booking.**

**Thank you for your referral to Bridgwater Veterinary Hospital and Wellness Centre.**