



SURGERY REFERRAL REQUEST

Dr. Geoffrey Hutchinson
Dr. Lyndell Levitt

SRF3

Do not write in this area

Referring Hospital	DATE
Referring Veterinarian (print)	Referring Doctor Phone Number <div style="text-align: right;">☆ ☆</div>

CLIENT

Client Last Name		First Name	
Street Address	City	Postal Code	
Home Phone	Cellular	★ Email	

PATIENT

Name	Breed	Species	Sex	Age (MM / DD / YYYY)
			M MN F FS	

REASON FOR REFERRAL

Current Concern(s) Requiring Referral
Relevant History, Comments, Special Concerns
Past Procedures Performed. (Radiographs, Ultrasound, Diagnostic Tests) <i>Please send radiographs with client or download digital radiographs directly.</i>
Current Treatment/Medications currently or previously given.

Appointment Date	Appointment Time	Booked By
Appointment Reminder done on	Date	Time BBVSH staff

Once you have faxed your referral, please contact our office to confirm receipt.

Phone 604-514-8383

Fax 604-514-1712