BOUNDARY BAY
VETERINARY SPECIALTY HOSPITAL

10436 173rd St., Surrey, BC, V4N 5H3
Phone: 604-514-8383
FAX: 604-427-2494
www.bbvsh.com | info@bbvsh.com

REFERRAL REQUEST

DATE: _____/_____/__________

REFERRAL TO:

- ☐ Critical Care*
- ☐ Cardiology
- ☐ Neurology
- ☐ Oncology
- ☐ Surgery
- ☐ Emergency
- ☐ Internal medicine
- ☐ Animal Rehabilitation
- ☐ Dentistry

* Critical Care: This is a specific referral to board-certified critical care specialist. If it is after hours, there will be a call-in fee.

TYPE:

☐ Direct Transfer / Immediate ****   ☐ Urgent *(1-2 days)*   ☐ Next available appointment

****Please call **604-514-8383** when sending direct transfers

ESTIMATED TIME OF ARRIVAL IF SENDING IMMEDIATELY: ____________________

REFERRING VETERINARIAN

Referring Hospital ____________________

Veterinarian ____________________

Daytime Phone ____________________ After Hours Phone ____________________

Email ____________________ Fax ____________________

Preferred Method of Contact ☐ Phone ☐ Fax ☐ Email

CLIENT INFORMATION

First Name ____________________ Last Name ____________________

Street Address ____________________ City ____________________ Postal Code __________

Home Phone ____________________ Mobile Phone ____________________

Email ____________________

PATIENT INFORMATION

Name ____________________ Breed ____________________

Species ____________________ Birthdate _______/ _____________/ ___________

Sex ☐ M ☐ MN ☐ F ☐ FS Fur Colour ______________ Weight ______________ ☐ lbs ☐ kg

REASON FOR REFERRAL *e.g. clinical history, PE findings, etc.*

____

____

____

____

____

____

PLEASE NOTE:

Please send all relevant records, lab results and diagnostic images. Once you have faxed your referral, please contact our office to confirm receipt.

PHONE: 604-514-8383 **FAX:** 604-427-2494

BOUNDARY BAY
VETERINARY SPECIALTY HOSPITAL

10436 173rd St., Surrey, BC, V4N 5H3
Phone: 604-514-8383
FAX: 604-427-2494
www.bbvsh.com | info@bbvsh.com

REFERRAL REQUEST

DIAGNOSTICS *e.g. lab reports. etc.*

____
____
____
____
____
____
____
____
____

TREATMENTS

____
____
____
____
____
____
____
____
____

MEDICATIONS & DOSAGES

____
____
____
____
____
____
____
____
____

RELEVANT RECORDS

RECORDS SENT BY ☐ Fax ☐ Email ☐ Coming with owner

PLEASE NOTE:

Please send all relevant records, lab results and diagnostic images. Once you have faxed your referral, please contact our office to confirm receipt.

PHONE: 604-514-8383 **FAX:** 604-427-2494