



Burlington Veterinary Emergency and Referral Hospital

775 Woodview Road Burlington, Ontario L7N 3S7
(905) 637-8111
www.bverh.com

RDVM Name: _____ **Hospital:** _____
Phone # : _____ **Fax:** _____ **Email:** _____

Client Name: _____
Address: _____ **City/Postal Code:** _____
Home # : _____ **Cell #/Other:** _____

Patient Name: _____ **M / F / MN / FS** **Date of Birth:** _____
Breed: _____ **Colour:** _____ **Weight (kg)** _____

Reason For Referral: _____

Summary of Visit & Physical Exam Findings:

Procedures & Dx/Lab Tests Performed & Significant Results:

Current Therapy & Medications:

Included: **Medical Records** **Lab Results** **Radiographs** **Other** _____

Should we contact you in significant changes occur overnight? **Yes** **No** **Phone#:** _____

Do you wish the patient return in the am? **Yes** **No** **Time:** _____

Tests Pending*: **Antech** **Idexx** **AHL** **Other**

Special Requests/ Other Information:

FAX 905-637-4229 OR EMAIL bverh1@gmail.com

*Please call lab to ensure we have permission to access patient's after-hours lab results.