



Small Animal Referral Service
Mark E.H. Smith Inc

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Diplomate, American College of Veterinary Surgeons

Date of referral: _____

Client & Patient Information (if you have a label, please place here):

Client Name: _____ Patient Name: _____

Client phone H) _____ W) _____

Species: _____ Breed: _____ Age/DOB: _____ FI FS MI MN

Veterinarian Information:

Referring Hospital: _____ Veterinarian: _____

Phone: _____ After-hours phone: _____

Fax: _____ Email: _____

Request for Service at:

Aldergrove Animal Hospital
tel: 604-856-7707
fax: 604-856-1255
email: wecare@aldergrovetvet.com

Granville Island Veterinary Hospital
tel: 604-734-7744
fax: 604-733-0412
email: info@bcpetvet.com

Canada West Veterinary Specialists
tel: 604-473-4882
fax: 604-473-4898
email: _____

Scottsdale Veterinary Hospital
tel: 604-590-2121
fax: 604-590-0293
email: scovethosp@telus.net

Chase River Veterinary Hospital
tel: 250-591-4050
fax: 250-591-4054
email: info@chaserivervet.ca

Priority: Next available Urgent

Reason for Referral: _____

History: _____

Clinical Signs: _____

Relevant Clinical Pathology data: _____

Current Treatments: _____

Radiographs: not done coming with owner emailed

Special Requests: _____

We prefer reports by: Fax Email