West Coast Veterinary Dental Services

Phone 604-473-3605 Fax 604-473-3620 Email team@wcvds.ca

Consult and Procedure Referral

Today's Date _____

Client Information

Client Last Name(s):	Client First Name(s):	
Street Address:	City:	Postal Code:
Primary Number:	Other:	Email:

Has this client been to our clinic before? ☐ Yes ☐ No

Patient Information

Name:		Species & Breed:	Colour:
Sex:	Weight (kg):	DOB (D/M/Y):	Age:

Has this patient been to our clinic before? ☐ Yes ☐ No

Referring Clinic Information

Veterinary Hospital:	Work #
Veterinarian:	Fax #
Clinic Email:	

Refer to: ☐ ANY ☐ Dr. Loïc Legendre ☐ Dr. Angie Bebel
☐ Dr. Gerad Cantin ☐ Dr. Olivia Saunders (Resident)

This patient is at high risk for GA, and requires Dr. Nancy Brock (Board Certified Anesthesiologist) to be involved? ☐ YES ☐ NO ☐ NO, but the client has requested

Status: ☐ Emergency (please **call** upon submission) ☐ Urgent ☐ As Available

Reason for Referral and Patient History (please print/write legibly and use another page if needed)

Questions:
Have **dental radiographs** been obtained in the last year? ☐ Yes ☐ No If yes, please send as JPEG.

Bloodwork (CBC/Chem) is required on pets 6 years and older
Has blood work been obtained in the last 6 months? ☐ Yes ☐ No

Thoracic radiographs (3-view) <u>need an interpretation</u> and are required on all pets 10 years and older - and ALL brachycephalic canine breeds, regardless of age *please send any radiographs as JPEG*

Have thoracic radiographs been obtained? ☐ Yes ☐ No
The radiographs have been interpreted by: ☐ RDVM and/or ☐ Radiologist

Cardiac ultrasounds are required on any patient with heart disease (incl. murmurs and arrythmias)
Has an ultrasound/echocardiogram been performed? ☐ Yes ☐ No

If required, would you like our team to arrange this at our clinic with Dr. Janet Nieckarz (board-certified radiologist)?
☐ Yes ☐ No

Has the patient been diagnosed with any of the following? Please check all that apply

☐ Heart Disease ☐ Liver Disease ☐ Seizure Disorders
☐ Kidney Disease ☐ Respiratory Disease ☐ Diabetes

Has the patient shown any of the following clinical signs? Please check all that apply
☐ Coughing ☐ Sneezing ☐ Vomiting ☐ Anxiety/High Stress
☐ Diarrhea ☐ Respiratory Disease ☐ Aggression/Caution

What medication is the patient currently on?

_____
_____
_____

Any other disease, illness, or allergies, please describe and give details below:

_____
_____
_____

Upon submission of this referral **please obtain and attach the last 2 years of the patient's medical record** along with all completed diagnostics.