



INTERNAL MEDICINE CONSULT REQUEST

Referring Hospital & Veterinarian		DATE
Referring Veterinarian (print)		<i>Referring Doctor Signature</i>
		☆ ☆
If your clinic is closed and hospitalization is advised, would you like us to admit the patient to AECFV? YES NO		

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	
CURRENT MEDICAL CONCERN(S) REQUIRING CONSULTATION				
1.		3.		
2.		4.		
RELEVANT HISTORY, COMMENTS OR SPECIAL CONCERNS				

PROCEDURES PERFORMED

(Radiographs, Ultrasound, Diagnostic Tests, Medications/OTC/Supplements, Previous Consults)

Please be aware this is a consultation appointment only. All efforts will be provided to assist in coordinating the recommended diagnostics to be performed at AECFV or your clinic. Note diagnostic capability at this time is not all encompassing. Internal Medicine Consultation may result in an additional referral to a specialty center for addition diagnostics.

**PLEASE FORWARD COMPLETE MEDICAL RECORD BY MAIL, FAX OR EMAIL
PRIOR TO CONSULTATION APPOINTMENT.**

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

Phone 604-514-1711

Fax 604-514-1712

aecfv@telus.net

August/09