



ONCOLOGY/HEMATOLOGY CONSULT REQUEST

Dr. Sarah Charney

Referring Hospital & Veterinarian	DATE
Referring Veterinarian (print)	Referring Veterinarian Phone #

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	

REASON FOR REFERRAL

<p>Current Concern(s) Requiring Consultation</p> <p>Has a biopsy or cytology been performed (not required) If so, what were the results? If possible, please attach results to this request.</p> <p>Past Procedures Performed. (Radiographs, Ultrasound, Diagnostic Tests) <i>Please send radiographs with client.</i></p> <p>Current Treatment/Medications currently or previously given.</p>

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

Once you have faxed your referral, please contact our office to confirm receipt.

Phone 604-514-8383

Fax 604-514-1712