Caledon Mountain Veterinary Hospital
Orthopedic Consult Surgery Referral

29 Elizabeth Street, Caledon, ON, L7K 0W7
www.caledonvet.com
cmvhreception@gmail.com
Tel: 519-927-5775 / Fax: 519-927-3791

REFERRAL INFORMATION

RDVM: ______________________________ Hospital: ______________________________

Referring Hospital's Email Address:____

Date: _______________ Phone: _____________________ Fax: _____________________

Owner Name: ____________________________ Phone: ____________________________

Address: ______________________________ City: _____________ Postal Code: __________

Patient Name: ______________________ Date of Birth: ___ /____/______ Species: Canine / Feline

Breed: ________________________________ Sex: F / FS / M / MN Weight (kg): __________

Vaccine Status: ___________________________ **Patients MUST BE current on their rabies vaccine**

PATIENT HISTORY

Presenting orthopedic complaint: ____

History:

Current therapy/medications:

Other Health Concerns/Previous Anesthetic Alerts/Behavioural Alerts:

Were x-rays taken? Yes / No Imaging Interpretation: ______________________________________

****Please note that pre-anesthetic screening is mandatory for surgery. Blood work needs to be completed 7-10 days prior to the surgical appointment by the referring hospital. Abnormal results would change the surgical/anesthetic approach and overall care of the patient****

APPOINTMENT DATE: ____ TIME: _____________________

Please send radiographs/scans with patient at time of consultation/surgery.

BLOOD WORK RESULTS MUST BE sent with this form