HEALTHY. HAPPY PETS.

OPHTHALMOLOGY REFERRAL FORM

APPOINTMENT DATE ____________________________________ APPOINTMENT TIME ___________________________

ACCOMPANYING REPORTS/IMAGES

CBC ____ Chemistry ____ U/A ____ Radiographs ____ Other (specify) ________________

How Were Reports Provided? Client ____ Fax ____ Mail ____

REFERRING VETERINARIAN INFORMATION

Name _________________________________ Veterinary Clinic ____
Address ________________________________ City _______________________ Province _____ Postal Code ____________
Telephone ________________ Fax ________________ E-mail ____

OWNER INFORMATION

Name _______________________________________ Telephone (H/W) ___________________/_____________________
Address____________________________ City ______________________ Province ______Postal Code ________________

PATIENT INFORMATION

Name ________________________ Species ________________________ Breed ________________________
Date of Birth ___________________ Sex Male ____ Female ____ Reproductive Status intact ___ spayed/castrated ______
Date of last vaccinations ________________

MEDICAL INFORMATION

History (Medical And Surgical)/Clinical Findings

____

____

____

____

Concurrent Medical Illnesses

____

Current Medications (including herbs/holistic medications - include dosages (mg/kg and frequencies))

____

____

____

Presumptive Diagnosis (if Any) ____

Previous Anesthesia Complications (if yes, explain)

____

____

Primary Concerns

____

____

Ophthalmology - Cheryl L. Cullen, DVM, MVetSc, DACVO

Neuro-ophthalmology/Audiology - Aubrey A. Webb, DVM, PhD (Neuroscience)

516 Pinewood Road, Riverview NB E1B 5J9 Telephone: 506-204-8433 Fax: 506-204-8633 Email: cullenwebb@me.com