

### Chemotherapy Referral Form

#### REFERRING VETERINARY INFORMATION

Dr. \_\_\_\_\_ Hospital Name: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

#### CLIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

#### PATIENT INFORMATION

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Sex:  M  F Neutered/Spayed:  Yes  No Colour: \_\_\_\_\_ Weight: \_\_\_\_\_

Vaccine Status: \_\_\_\_\_ Underlying Condition: \_\_\_\_\_

#### HISTORY

Please include the following information with your referral:

- Date of Initial Diagnosis:

Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

- Staging Results (please check all that apply):

- Radiographs
- Ultrasound
- Blood Testing
- Biopsy Results

- Current Medications:

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Treatment with chemotherapy requires an initial consultation.

We will contact your client to schedule the consultation once we receive the complete history of the patient.