



## VALLEYVIEW VETERINARY CLINIC

### CT REFERRAL FORM

Dr. Maricle DVM; Dr. Tobey DVM, DACVP & Associates

1662 Valleyview Dr

Kamloops, BC

V2C 4B5

Ph: 250-374-5649

#### REFERRING CLINIC INFORMATION:

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

Clinic/Hospital: \_\_\_\_\_ Veterinarian: \_\_\_\_\_

Clinic/ Contact Phone Numbers: \_\_\_\_\_

Email For Report: \_\_\_\_\_

#### CLIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

#### PATIENT INFORMATION:

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: (circle one) M MN F FS Age: (MM/DD/YYYY) \_\_\_\_\_ Weight: \_\_\_\_\_ Color: \_\_\_\_\_

Current Medications/Treatments: \_\_\_\_\_

Demeanor: \_\_\_\_\_

Allergies/Drug Interactions: \_\_\_\_\_

Sedation/Anesthetic Risk: \_\_\_\_\_

**RELEVANT HISTORY:**

**\*\*\*\*\*NOTE\*\*\*\*\***

**THIS INFORMATION WILL BE FORWARDED AS WRITTEN TO THE SPECIALIST READING OUT THE IMAGES**

History and Primary Ddx:

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Diagnostic Questions and/or Concerns:

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Area of CT requested and Special Specifications:

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Anesthetic Risk and Current medications:

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**PLEASE SEND VIA FAX OR EMAIL.**

**Fax: 250-374-1235**

**Email: [valleyviewvet@telus.net](mailto:valleyviewvet@telus.net)**

**Please call to confirm that we have received this request**

**Phone: 250-374-5649**