Western Canada
Veterinary Eye Specialists Inc.

460 E. Columbia St
New Westminster, B.C., V3L 3X5
Tel: 604-549-4944
Fax: 604-549-4941

Referral Information

Date: ______________

Patient Information

Owner Name: ________________
Phone Numbers (*Please include all contact numbers*): ______________________________
____
Address & Postal Code: ____________________________________
____

Patient Name: ________________ Breed: ______________________
Sex: ______________________ Age: ______________________
Temperament: ________________ Vaccination Status**:** ______________
Anesthetic Risk: ____

Referring Veterinarian Information

Veterinarian: ________________ Hospital Name: ________________
Phone Number: ________________ Fax Number: ________________

Status

Urgent ________ Non-Urgent ________ Emergency ________

History of Ocular Condition

Please include all previous and current medical therapies, duration and response. Please include any lab work, as well as relevant history.

Reason For Referral