



460 E. Columbia St
New Westminster, B.C., V3L 3X5
Tel: 604-777-4448 (77-SIGHT)
Fax: 604-777-4411

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