

**Referral Form**

**Referring Clinic:**

**Referring Veterinarian**:

**Email:**

**Phone:**

**Veterinarian you are Referring to:** 

**Owner:**

**Phone:**

**Patient:**

**Breed:**

**Age:**

**Mare**  **Gelding**  **Stallion**

**Discipline:**

**Primary Complaint:**

**Duration:**

**History:**

**Radiographs Performed:** Yes  No

**Findings:**

**Ultrasonography Performed:** Yes  No

**Findings:**

**Treatments:**

**Response to Treatments:**

**Medications:**

**Response to Medications:**

**Remarks/Requests:**

Please email/fax all medical records and diagnostic imaging

admin@pmvetservices.com Fax: 604-856-2676

Thank you for your referral!