Pacific Animal Eye Specialty Services - Kelowna

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Date of Referral: _____

Desired method of communication:
☐ Fax
☐ email: _____

OWNER and PATIENT INFORMATION

Owner Name:_____
Phone Numbers (*Please include all contact numbers):*_____
Address: _____
City:_____Postal Code:_____

Patient Name:_____ Breed:_____
Sex: _____ Date of Birth: _____ Temperament: _____
Vaccination Status**:** _____ Anesthetic Risk: _____

REFERRING VETERINARIAN INFORMATION

Veterinarian: _____ Hospital Name: _____
Phone Number: _____ Fax Number: _____

STATUS OF REFERRAL

Non-Urgent ☐ Urgent ☐ Emergency ☐

Reason for Referral/Suspected condition:_____

History of Ocular Condition (include prior and current medical therapies, duration, and response)

Brief summary of systemic disease (historic or current)