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## Orthopedic Surgery Referral Form – Dr. Vasile Dzsurdzsa

### Referring Hospital

Hospital Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_

Email: \_\_\_\_\_

### Client Information

Client Name(s): \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Full Address: \_\_\_\_\_

Email: \_\_\_\_\_

### Patient Information

Pet's Name: \_\_\_\_\_  F  FS  M  MN

Age: \_\_\_\_\_ Breed: \_\_\_\_\_ Current Weight: \_\_\_\_\_  KGS  LBS

Presenting Complaint/Diagnoses:

\_\_\_\_\_

History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications/Dosages:

\_\_\_\_\_

\_\_\_\_\_

Medical Records/Lab Results:  Emailed  Faxed

Radiographs:  Emailed  Faxed  Not Done

*Thank you for trusting us to care for your patient. If you have any questions, please don't hesitate to contact us.*