North West Veterinary Dermatology Services Ltd.

Specializing in itch relief, allergy management and ear diseases

PATIENT REFERRAL FORM

Date:

CLIENT AND PATIENT INFORMATION			REFERRING VETERINARIAN INFORMATION
Client(s) Name(s):			Veterinarian:
Phone: (h) (c) (w)			Practice:
E-mail(s):			E-mail:
Patient Name:	Age/DOB:		Phone:
Species: ☐ Canine ☐ Feline ☐ Other:	Breed:	Weight (kg):	Sex: ☐ Female ☐ Intact ☐ Spayed ☐ Male ☐ Intact ☐ Neutered

REASON FOR REFERRAL (chief complaint).

☐ Pruritus/itching/allergies ☐ Ear disease ☐ Alopecia (Hairl Loss) ☐ Pododermatitis ☐ Nail disorder

☐ Other:

CLINICAL SIGNS AND HISTORY. Please include duration and seasonality of disease, degree of pruritus.

Vancouver, BC
P: 604-428-0070
F: 844-273-1078
E: office@vetderm.ca

Surrey, BC
P: 604-428-0070
F: 844-273-1078
E: office@vetderm.ca

Victoria, BC
P: 250-475-2495
F: 250-475-1909
E: centralvictoria@vca.com

St. Albert, AB
P: 780-470-5100
F: 844-818-7514
E: edmonton@vetderm.ca

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LABWORK. **Please attach results to ensure they are <u>available for review at the time of the appointment</u>.**

☐ Skin cytology. Results:	☐ Complete blood count
	☐ Biochemistry profile
☐ Ear cytology. Results:	☐ Thyroid profile
	☐ Cushings testing (ACTH stimulation test, LDDST)
☐ Skin scrapings:	☐ Bacterial cultures and sensitivity panel
☐ Negative or ☐ Positive for parasites?	☐ Serum allergy testing
	☐ Intradermal allergy testing
☐ Fungal cultures:	☐ Skin biopsies
☐ Negative or ☐ Positive for dermatophytes?	☐ Other:

MEDICATIONS. Please list current or previously used treatments and their efficacy.

PREVENTATIVES. Is flea, tick, or heartworm prevention used in this patient? If so, which products?

DIETS. Has a hypoallergenic diet been tried? ☐ YES ☐ NO
If so, which diets were used?
Was any improvement seen?

ADVERSE REACTIONS. Are you aware of any adverse reactions to drugs or vaccines in this patient?

NON-DERMATOLOGICAL DISEASES. Are there any other health problems aside from skin or ear disease?

ADDITIONAL INFORMATION. Pet's temperament, comments or special requests.

Please fax/email the **Patient Referral Form, a copy of the relevant medical records and labwork.**
We will contact the client to schedule an appointment. They will be asked to complete additional forms.
We will email a written report for each visit. **Thank you for your referral.**

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