



SOUTHERN ALBERTA VETERINARY EMERGENCY  
OKOTOKS, ALBERTA 403-995-3270

## Referral Form – Orthopaedic Surgery

Date: \_\_\_\_\_

NON-URGENT REFERRAL

URGENT REFERRAL

### Referring Veterinarian Information

Dr Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Client Information

Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ City, Province: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ Breed: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ Sex: \_\_\_\_\_

### Orthopaedic Referral Information

Dr. Marco Bregliano DVM, Dip.ACT

Reason for Referral/Case Details:

Relevant medical history and medication:

### Please indicate how you are sending the following:

Referral Form: \_\_\_\_\_ Lab Results: \_\_\_\_\_  
Medical Records: \_\_\_\_\_ Radiographs: \_\_\_\_\_