3577 WALKER ROAD, WINDSOR, ON N8W 3S5
TEL: 519-972-9000, FAX: 519-972-9132
EMAIL: rvts@wrah.ca
www.walkerroadanimalhospital.com

Date:________________ Referring Hospital:____________________________ Referring DVM__________________

Reason for Referral____

Client Information

Client Name____________________________ Address_________________________ City __________________

Postal Code__________________ Client Phone___________________________

Patient Information

Patient Name____________________________ Species__________________ Breed_________________________

Age_________ Sex__________ Weight__________

Treatments

IV Catheter: Date_______________ Site_________________________ Size____________________

IV Fluids: Fluid Type ________________________ Fluid Rate________________

Treatments Given:	Dose:	Route:	Time:

Diagnostics:

Please list diagnostics completed and attach results/include radiographs if possible:

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Notes and Instructions:

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Patient Transportation Release (Owners to fill out and sign):

I, _____________________________ will be transporting________________________ to Walker Road Animal Hospital for continued medical care. I understand all instructions given to me by _____________________________. I will not hold the referring hospital or any staff thereof, or the staff of Walker Road Animal Hospital liable for any unforeseen circumstances that should occur during transportation.

Signature____ Date__________________________________