NIAGARA FALLS
ANIMAL MEDICAL CENTRE
Since 1974

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6838 Morrison St
Niagara Falls, ON
L2E 6Z8

REFERRAL REQUEST

Date of Appointment: ________________

Time of Appointment:________________

RDVM: ________________________ Hospital:_______________________________

Phone:___________________ Fax:_______________ Email:______________________

Client:_______________________________Phone:______________________________

Address:___________________________________City:_________________________

Postal Code:______________ Additional Phone #: ______________________________

Patient:____________________ Breed:______________Age:____Sex:____Wt:_______

Brief Summary of History and Physical Findings:
(Email of relative hx lab work would be preferred over fax. Or can be sent with client)

Lab Tests:____
Radiographs:____
Please send Radiographs with client or digital rads email to drmergl@bellnet.ca
Current Medications:_________________________**Current Diet:**_______________
Tentative Diagnosis:

Special Requests: