Dr. Rona Sherebrin DVM, CVA

Veterinary Acupuncture &
Traditional Chinese Medicine

Referral Request:

Referring Veterinarian:____
Clinic:____
Address____
Phone:___________________Fax_______________Email_________________

Client Name: ____
Patient Name: ________________________ Species: _______________________
Breed: ______________________________ Sex: ____ Neutered?___ At age? __
Birthdate (if known, or approximate age): ________________________________
Address ____
Phone: h) __________w) _____________c) __________Email__________________

Diagnosis or primary complaint: ____
History: ____
____
Past and Current Therapy: ____
____
____
Side effects (if any)____
Laboratory data?
yes ☐ attached ☐ client will provide ☐
no ☐
Radiography?
yes ☐ attached ☐ client will provide ☐
no ☐
How do you wish to receive the follow-up report:
E-mail ☐
Fax ☐
Mail ☐
Signature of referring veterinarian: ______________________
Date: _______________________

Please fax to

Secord Animal Hospital(416) 486-1795

Thank you for your referral. All patients will be referred back to you for primary care.