ALLIES IN INTERNAL MEDICINE (AIM)
MOBILE VETERINARY IM SPECIALISTS

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BRINGING INSIGHT ONSITE

INTERNAL MEDICINE REFERRAL FORM

DATE OF REFERRAL (Month/Day/Year)	

OWNER(S) INFORMATION (MANDATORY FIELDS*)

First and last name(s)*	
Unit/suite/apt, street number, street*	
City, province, postal code*	
Home phone number*	
Cell phone number	
Work phone number	
Email	

REFERRING VETERINARIAN INFORMATION (MANDATORY FIELDS*)

First and last name*	
Practice name*	
Unit/suite, street number, street name*	
City, province, postal code*	
Daytime phone number*	
After hours phone number	
Fax number*	
Email (if available)*	

INTERNAL MEDICINE REFERRAL REPORT PREFERENCE (CIRCLE ONE)

FAX	EMAIL	MAIL

PATIENT INFORMATION (MANDATORY FIELDS*)

Name*	
Age or date of birth*	
Species (circle one)*	Canine or Feline
Breed*	
Gender (circle one)*	FI FS MI MN
Last body weight* and date	
Last vaccination date and type	
Vaccinated for Leptospirosis (circle one)*	Yes No Unknown N/A
FeLV/FIV status if known*	Negative Positive Unknown N/A

REASON FOR REFERRAL:

KNOWN DRUG OR ANESTHETIC REACTIONS:

PLEASE PROVIDE A SHORT CHRONOLOGICAL CASE HISTORY SUMMARY RELEVANT TO REASON FOR REFERRAL (example: onset of problem, list of diagnostic testing done, summary of any treatments/medications attempted (drug/dose/duration) and any response to treatment, and list of any therapeutic diets tried and response. Please list current therapies and doses. Add another page if needed. Do not send entire patient record, only recent records relevant to reason for referral.

PLEASE LIST CURRENT MEDICATIONS AND DIETS (include formulation + doses please):

Please attach copies of all recent or historical diagnostic testing performed (lab tests, cytology or histopathology reports, ultrasound or radiology reports) relevant to reason for referral.

Radiographs (circle one) not done being sent with client being couriered

LIST RELEVANT RADIOGRAPHS DONE AND DATE. Have radiographs available for review at the time of consultation appointment. Do not email radiographs.

Please fax the completed form + additional information to 1.888.812.3779.
Our office will contact your clinic within 24 hours of receipt to coordinate a referral consultation/procedure date. Please note that we do not contact the client directly to set up the initial consultation appointment.

Please contact Dr. Mirkovic at: 604.812.7916 or email: TMirkovic@AlliesInIM.com to set up a referral consultation appointment or to book an internal medicine diagnostic procedure for your patient.

Thank you for your referral!

A completed Referral Form and History must be received for the consultation booking to be confirmed.