



Referral Request

Date: _____

Please check one of the following options:

- Acupuncture Referral with Dr. Carlson
- Chiropractic Referral with Dr. Carlson
- Dentistry Referral with Dr. Calderwood
- Ophthalmology Referral with Dr. Wisnewski
- Rehabilitation Referral with Dr. Wisnewski
- Orthopedic Referral with Dr. Burchill

Please check the following options:

- Consultation PWVC to Contact rDVM
- Immediate Care or Evaluation PWVC to Contact Client

Referring Veterinary Information:

DVM: _____

Clinic: _____

Phone: _____

Fax: _____

Email: _____

Client Information:

Client Name: _____

Address: _____

City/Zip: _____

Phone: _____

Email: _____

Patient Information:

Name: _____

DOB: _____

Breed: _____

Sex: _____

Color: _____



Please email or fax **all medical records and/or radiographs** to our clinic at time of request to:
prairiewindsveterinary@gmail.com or (701) 356-5601. Thank you.