



**VETERINARY  
EMERGENCY  
CLINIC**

**Veterinary Emergency Clinic / Referral Centre**

920 Yonge St. Suite 117, Toronto ON M4W 3C7

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**REQUEST FOR DENTISTRY REFERRAL**

Sharon French DVM, FAVD  
Danny DeRose DVM, DipAVDC

Referring Veterinarian: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Clinic: \_\_\_\_\_

Clinic Phone Number: \_\_\_\_\_ Clinic Fax Number: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client Phone Number: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Presenting Complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Treatments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Therapy/Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Health Concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IT IS VERY IMPORTANT TO PLEASE MAKE SURE THAT AGE RELATED PRE-OP BLOOD WORK INCLUDING A PLATELET COUNT IS DONE WITHIN 2 WEEKS PRIOR TO THE APPOINTMENT TIME.**

Laboratory Data Included:      Yes                      No

Radiographs Included              Yes                      No