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** ◯

Email form to: info@vectoronto.com