



## 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:

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Previous Treatments:

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Current Therapy/Medications:

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Other Health Concerns:

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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](mailto:info@vectoronto.com)