VETERINARY EMERGENCY CLINIC
920 Yonge Street, #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:

_____
_____
_____
_____
_____

IMPORTANT - PLEASE ENSURE:

1) The complete medical history (incl diagnostics & imaging) is included with this form.
2) Age related pre-op bloodwork (incl platelet count) is completed within 2 weeks prior to the appointment.

Laboratory Data Included: **Yes** ◯ **No** ◯

Radiographs Included: **Yes** ◯ **No** ◯

Email form to: info@vectoronto.com