ANIMAL DENTAL SPECIALISTS

OF UPSTATE NEW YORK

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DENTAL REFERRAL FORM

Today's Date ________________

Referring Veterinarian ____

Referring Hospital ____

Hospital Address ____

Hospital Phone (   ) ______ - _______ Hospital Fax (   ) ______ - _______

Email Address ____

Owner's Name(s) ____

Owner's Address ____

Owner's Home Phone (   ) _____ - ______ Cell Phone (   ) _____ - ______

Email Address ____

Pet's Name ____

Species ❑ Canine ❑ Feline Date of Birth/Age ___________________ Weight __________

Breed ___________________________________ Color/Markings _______________________

Sex: ❑ M ❑ MN ❑ F ❑ FS **Use:** ❑ Pet ❑ Working ❑ Show

Vaccination Dates (please note date given and duration of immunity): _____________________________________

____

History and Clinical Findings: ____

____

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____

____

Medications: ____

Are you able to examine this patient's mouth without sedation? ____

Has this patient ever received pre-visit pharmaceuticals? If so, what types and dosages and what were the effects?

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____

Comments: ____

____

Radiographs Sent: ❑ Yes ❑ No **Lab Results Sent:** ❑ Yes ❑ No