ANIMAL DENTISTRY
REFERRAL SERVICES

Referral Form

Thank you for your referral.
On most occasions, we are able to see your patient within 24 hours of your referral. Please contact us by phone if your referral is an oral emergency.

You can download this form at www.tooth.vet as well.

Date: _____

Referring Clinic: _____ Referring Doctor: _____

Email address: hosp doctor (circle)_____

Clinic phone number: _____ Fax number: _____

Owner Name: _____

Phone number: (home) _____ (cell) _____ (email)_____

Patient Name: _____ Species: canine / feline / small mammal Breed: _____

DOB: _____ Sex: M F Spayed/Neutered? Y N Color: _____

Client has been instructed to call to schedule appointment?: Y N

Nature of referral:

Presenting Complaint and History:

Tentative Diagnosis:

Dental Radiographs taken? Y N Skull Radiographs taken? Y N

Sent with the owner? Y N Emailed to us? Y N (toothvetconsult@gmail.com)

Labwork done? (To expedite your client's visit we recommend running CBC Chem Elec prior to patient appt) Y N

Additonal diagnostics or Comments:

How would you prefer we communicate with you regarding this case? (circle Email, Fax, and/or Mail)

Email report and radiographic images to: _____(default communication)
Fax report Mail report without images

To make things as smooth as possible for your client, please send this referral form along with labwork, any oral radiographs, and biopsy results via email to: toothvetconsult@gmail.com. Please call 515-344-3776 to schedule a remote contact session if you need assistance with electronic contact.