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Board Certified Veterinary Dentist™
Diplomate American Veterinary Dental College
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Specialty Referral Veterinary Dentistry Services

PATIENT REFERRAL FORM

DATE (DD/MM/YY): _____/_____/_____

OWNER DETAILS

Owner Name(s): _____

Address: _____

_____Suburb:_____

City/Town: _____ Zip Code: _____

Phone (H): _____ (M) _____

Phone (W): _____

E-mail: _____

Please ensure that BOTH a phone number and e-mail address are provided.

PATIENT DETAILS

Pet Name: _____

Age: _____ Sex (M/F): _____ Desexed (Y/N): _____

Breed: _____ Colour: _____

PERTINENT MEDICAL HISTORY

Presenting Complaint: _____

_____

Dental Radiographs: Y / N

Clinical Photographs: Y / N

Current Medications: _____

_____

Summary of Relevant Clinical History (*please attach detailed history in a separate file along with this referral form):*

Clinical History (*continued*):

REFERRING VETERINARIAN DETAILS

Name: _____

Clinic: _____

Address: _____

Suburb: _____City/Town: _____ Zip: _____

Phone number: _____

E-mail: _____

Preferred mode of contact for follow up: E-mail / Phone Call / Both

Thank you very much for the referral. New Zealand Veterinary Dentistry Ltd. will organise a consultation with your client and any relevant clinical history will be forwarded once consultation and/or surgery has been completed. If you have any questions or concerns during this process please do not hesitate to contact us on (027) 256-5652.

Please e-mail all forms and any relevant documents to referrals@nzvetdentistry.com