



DENTAL REFERRAL FORM

REFERRING VETERINARIAN _____

REFERRING HOSPITAL _____ TELEPHONE _____

ADDRESS _____

FAX _____ DATE: _____

BEST WAY TO COMMUNICATE WITH YOU? E-MAIL: _____ FAX: _____ MAIL: _____

OWNER'S NAME _____ HOME PHONE _____

ADDRESS _____ WK/CELL PHONE _____

PET'S NAME _____ DATE OF BIRTH _____ WEIGHT _____

SPECIES _____ BREED _____ COLOR _____

SEX: M MN F FS

USE: PET WORKING SHOW

Vaccination History: _____

History and Clinical Findings: _____

Comments _____

X-Rays Sent: Yes No

Lab Results Sent: Yes No

Thank you for referring this patient to the Animal Dental Specialists of Upstate New York for evaluation and/or treatment. Animals referred to Dr. Davis will not be accepted as routine patients of the Lyndon Veterinary Clinic, nor will owners of said animals be accepted as routine clientele.

**6867 East Genesee Street • Fayetteville, NY 13066
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