



ANIMAL DENTAL SPECIALISTS

OF UPSTATE NEW YORK

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Fayetteville, New York 13066

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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

Rabies Vaccination Date Given and Duration of Immunity: _____

History and Clinical Findings: _____

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?

Comments: _____

Please email patient's complete medical history to contact@adsuny.com.

Radiographs Sent: Yes No

Lab Results Sent: Yes No