Dental Referral Form

Please complete this form and return it along with all radiographs, bloodwork results, and medical history within 48 hours of receipt to info@eastownvet.com.

Please Note: The following vaccinations and diagnostics are required to be current for all non-emergency dental procedures:

Canines: Rabies, DHPP, and a negative heartworm test.

Felines: Rabies and FVRCP.

Date ________ Referring Clinician ________ Phone Number ________

Email ________ Clinic Name ________

Client Information

Name ________ Phone Number ________ Email Address ________

Patient Information

Pet Name ________ Age / DOB ________ Species ________

Sex: M / MN / F / FS
(Circle One)

Breed ________ Color ________

Referral Information

Reason for Referral / Chief Complaint

____

____

Is this an urgent referral? Y / N
(Circle One)

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VETERINARY CLINIC

Vaccination Due Dates

Rabies	DHPP	FVRCP
Date:	Date:	Date:

Diagnostics / Procedures Due Dates

Heartworm Test (neg)	CBC	Full Chemistry
Date:	Date:	Date:

Known Systemic Health Concerns?

Disease / Condition	Date of Diagnosis	Is the patient receiving medical therapy for this condition?

Current Medications

Drug	Dose (mg)	Frequency	Route (PO/SQ/TM/etc.)

Any known allergies, drug reactions or sensitivities? Y / N

If yes, explain: ____

____

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