



REFERRAL FORM

Please print and fax or mail to us

CLIENT INFORMATION

Name _____ Occupation _____
Address _____ Work phone _____
Address _____ Note _____
Home Phone _____

PATIENT INFORMATION

Name _____ Species _____ Breed _____
Date of Birth _____ Gender (circle) M F Neutered? Y N Color _____
Weight _____ Diet _____
Chew Toys _____ Oral Habits (circle): Bites cage Chews rocks Excessive toy chewing
Other (specify) _____

Use (circle all that apply)

Pet Show Obedience Breeding Police Shutzhund Working Therapy Zoo/exhibit Wild

Do you brush your pet's teeth? Yes No How often? Daily Weekly Monthly Less often

Home care products used: _____

Note: _____

REFERRING DOCTOR/PRACTICE INFORMATION

Dr. _____ Practice name _____

Practice address _____

Phone _____ Fax _____ E-mail _____

Note _____

REFERRAL INFORMATION

Reason for referral _____

Relevant history _____

Rabies vaccination date _____ expires _____ Last dental examination _____

Last dental prophylaxis (cleaning) date _____ performed by _____

Blood work results attached? Yes No Date blood drawn _____

Relevant results _____