

Montana Pet Dentistry and Oral Surgery - Patient Referral Information

Date: ____ / ____ / ____

Owner information

Owner's Name: _____

Owner's Phone:(Hm#) _____ (Cell#) _____

Pet Information

Name _____ Age or Birthday _____

Breed _____

Sex M NM F SF

Referring doctor information

Referring Doctor: _____

Referring Hospital: _____

Hospital Phone# _____

Hospital Fax # _____

Reason (s) for referral:

Brief history of current problems

Prior treatment & current medications

(list ALL current medications, including dosage and duration):

Diagnostic Test Results including lab and radiographic findings

Please fax copies of all pertinent lab work to 719-536-0484, or E-mail them to Trish@wellpets.com. Additional comments below:

- A copy can either be given to the client, mailed to us, or faxed to (719) 536-0484
- If you prefer, you can fill this form out and submit it online at www.montanapetdental.com → information for veterinarians