



## Animal Dental Center

Dale Kressin DVM, FAVD, Dipl. AVDC

### Patient Referral Form

Phone: 920-233-8409 or 1-888-598-6684 Fax: 920-233-1956

Date \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Owner \_\_\_\_\_ Pet \_\_\_\_\_ Phone \_\_\_\_\_

Species \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_ Sex: M MN F FS

Items accompanying patient: \_\_\_ Radiographs \_\_\_ Records \_\_\_ Blood work \_\_\_ Meds \_\_\_ Other \_\_\_\_\_

Date of Dental prophylaxis: \_\_\_\_\_ Do you offer dental radiology services? \_\_\_\_\_

**Previous dental work (extractions/oral surgery/other):**

**Therapeutics initiated:**

**Tentative Diagnosis:**

#### INSTRUCTIONS FOR THE ANIMAL DENTAL CENTER

- Consultation only  
 I wish to have the attending veterinarian E-mail Case Summary \_\_\_\_\_ E Mail \_\_\_\_\_  
 Requesting diagnosis and treatment

**IMPORTANT NOTE:** *In recognition of changes in patient condition, doctor's evaluation, and client wishes, the Animal Dental Center reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgement dictates.*

Referring Doctor \_\_\_\_\_ Hospital \_\_\_\_\_ E-mail \_\_\_\_\_

Clinic phone \_\_\_\_\_ Fax \_\_\_\_\_

Call me if \_\_\_\_\_