FAX TRANSMITTAL FORM

Attention: From:

Company: Date Sent:

Phone: Time Sent:

Fax: Number of Pages (including coversheet):

☐ Urgent ☐ Reply ☐ ASAP ☐ Please Comment ☐ Please Review ☐ For your info

Message:

When you fax the dental referral form, please also send the following:

1) Vaccine history should include a printout of the vaccine due dates as well as a copy of the actual Rabies certificate.
2) Any recent labwork, especially pre-anesthetic panels, and
3) Any of your notes related to the oral issue.

Have the client then call us to set up the initial dental consultation appointment.
DENTAL REFERRAL FORM
Date: __/__/__

CLIENT
Name: ______________________________________________________________
Address: ___________________________________________________________________
City/St/Zip: ___________________, ______     _______
Phone: (____)____-_________

ANIMAL
Name: ______________________________________________________________
Species: ___________________________________________________________________
Breed: ___________________________________________________________________
Color: ___________________________________________________________________
Sex: ___________________________ Weight: _____________________
DOB/Age: ___________________________________________________________________

REFERRAL
DVM: _________ Clinic: _______________________________________________
Phone: (____)____-__________ Address: _______________________________________
Fax: (____)____-__________City/St/Zip_______________.____  ___________
Doctor’s E-Mail: ___________________ @ ___________________.

I prefer to receive the patient dental record by: □ US mail □ E-mail □ Fax

*REASON FOR VISIT:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________