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 E-mail copies to montanadentalrecords@gmail.com. Additional comments below:

_____

_____

_____

_____

- **A copy can either be given to the client or mailed to us**
- **If you prefer, you can fill this form out and submit it online at www.montanapetdental.com ➔ information for veterinarians**