DENTAL REFFERAL

SITARA ANIMAL HOSPITAL
Teresa Jacobson, B.Sc., DVM & Associates
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Please complete form as signalment of patient is extremely important to case review.

Date: ___/___/_20___ Pages: __/__

Type of Referral: **Consultation / Procedure**: ☐ Yes ☐ No

OR **Email / Telephone Consultation:** ☐ Yes ☐ No
Fee: $60.00 +GST – Contact office for payment via VISA / MC or eTransfer. Cheques payable to Sitara Animal Hospital.

Status: ☐ Emergency ☐ Urgent ☐ Next Available

CLIENT INFORMATION

Last Name (s):		First Name (s):	
Street Address:		City:	Postal Code:
1st Phone #:	2nd #:	Email:	

Has this client / patient been to our clinic before? □ Yes □ No

PATIENT INFORMATION

Name:	Species:	Breed:	Colour:
Sex: M (N) / F (S)	D.O.B.:	Age:	Wt: Kg.

REFERRING CLINIC

Name:	Main Phone #
Veterinarian:	Fax #
Email:	Direct Phone #

Dental Radiographs: y / n (Email to jvsvet@shaw.ca) Photographs: y / n Insurance: y / n

Reason for Referral and History:

Office use only: Bloodwork rec'd □ Radiographs rec'd □ Medical Records rec'd □ Updated 10/22/20

QUESTIONS:

- Has recent blood work been done at your clinic (in last 3 months)?: ☐ Yes ☐ No ☐ Sent
  - We require blood work on animals:
  Up to 6 years : Pre-Anesthetic Panel
  7 years + : Senior Profile w/ Urinalysis

- Have chest radiographs been obtained? ☐ Yes ☐ No ☐ Sent
  - We require radiographs on animals 10 years and older

- Has an ultrasound / echo been performed previously? ☐ Yes ☐ No ☐ Sent

- Has patient been diagnosed with any of the following?

☐ Heart Disease ☐ Kidney Disease ☐ Liver Disease ☐ Thyroid Disease

☐ Diabetes ☐ Respiratory Disease ☐ Seizure Disorder ☐ Osteoarthritis

- Has patient recently shown any of the following clinical signs?

☐ Coughing ☐ Sneezing ☐ Vomiting ☐ Exercise Intolerance

☐ Diarrhea ☐ Anorexia ☐ Other

List medications patient is currently on / been dispensed:

_____
_____
_____
_____
_____

Please describe any other disease / illness in detail we should be aware of:

_____
_____
_____
_____

PLEASE ATTACH / EMAIL LAST 2 YEARS OF PATIENT'S MEDICAL HISTORY, INCLUDING ANY DENTAL CHARTS AND ANESTHESIA CHARTS. ONCE FULL RECORD RECEIVED, WE WILL CONTACT CLIENT TO BOOK APPOINTMENT.

This referral has been reviewed by (Doctor's name, please print): _____