ALBERTA VETERINARY DENTISTRY

Dr. Terrie Faber, DVM, FAVD
Fellow of the Academy of Veterinary Dentistry

# Dental Referral Request Form

Suite 107, 358 - 58 Avenue SW
Calgary, AB T2H-2M5
Ph: (403) 993-7146
F: (403) 258-1212
info@albertavetdentistry.com
www.albertavetdentistry.com

Date _____

**Referring Veterinarian** _____

Referring Hospital _____

Hospital E-mail _____

Hospital Phone Number (  ) _____-_____

**Owner's Name(s)** First _____ Last _____

Owner's Address _____

City _____ Postal Code _____

Owner's Primary Phone (  ) _____-_____ Alt. Phone (  ) _____-_____

**Pet's Name** _____

Breed _____ DOB _____ MM/DD/YYYY

Color _____ Sex F ☐ FS ☐ M ☐ MN ☐

Pet Insurance (if any) _____

Primary Dental Problem (please provide a brief synopsis including location, duration, and previous treatment to allow us to properly triage cases quickly):

_____

_____

Previous Dental History:

_____

_____

Pertinent medical history (diabetic, concurrent cardiac, renal, or liver disease etc.) and any current medications or supplements (please forward only *the most recent history* of the patient medical record):

_____

_____

Other comments - please include notes about behavior of the patient (friendly vs fractious) or any other relative information you feel we should know:

_____

_____

***If you have contacted our office via phone to schedule a consult on behalf of a client, please also include the date and time this is booked***: _____

**I would like Dr. Faber to call me prior to seeing the patient** ☐

**FOR OFFICE USE** Contacted: 1._____ 2._____ 3._____

Appt. time: _____ Appt. day: _____ Email: _____

Confirmation Email sent? ☐

**Thank you for your referral! We strive to return a satisfied client and a healthy, pain-free patient to your practice.**