EQUINE DENTISTRY REFERRAL REQUEST FORM

Summerleaze Vets Ltd, Summerleaze Farm, Kilmington, Axminster, Devon EX13 7RA
Tel: 01297 304007
summerleaze@summerleaze-vets.co.uk

Date ……..

Delete as appropriate: Client will contact Summerleaze Vets / Summerleaze Vets to contact Client

URGENT CASE? YES/NO ANIMAL INSURED? YES/NO

HAVE YOU PREVIOUSLY DISCUSSED THIS CASE WITH THE REFERRAL TEAM? YES/NO

HAS AN ESTIMATE BEEN GIVEN? YES/NO (if yes please specify amount) ……

Referring Equine Dental Technician ……

Contact Number …… Email Address ……

Clients Usual Veterinary Surgeon …… Practice ……

Has the clients usual Vet been informed of the problem? Yes/No
Has the horse been examined for this problem by a Vet? Yes/No

CLIENT DETAILS

Name ……

Address ……

Contact Numbers (home) …… (mobile) ……

PATIENT DETAILS

Name ……

Age …… Sex …… Breed ……

MEDICAL DETAILS

History leading to Referral

Diagnosis/Provisional Diagnosis

Previous Dental Treatment (please provide a copy of the chart if appropriate)

Current Medication

General Health and any other comments

Thank you- please return this form by post or email. Please feel free to photocopy for future use.
Stuart Altoft BVetMed Cert AVP(Equine Dentistry) GPCert(EP) BAEDT MRCVS