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 Veterinary Surgeon …… Practice/Branch ……

Contact Number …… Email Address ……

CLIENT DETAILS

Name ……

Address ……

Contact Numbers (home) …… (mobile) ……

PATIENT DETAILS

Name ……

Age …… Sex …… Breed ……

MEDICAL DETAILS

Previous Dental Treatment

History

Diagnostic Imaging YES/NO (please send digital images by email)

Diagnosis/Provisional Diagnosis

Current Medication / Treatment Plan (if any)

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