EQUINE DENTISTRY REFERRAL REQUEST FORM

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

Date............................

Delete as appropriate: Client will contact Summerleaze / Summerleaze 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 (and branch if appropriate)...
Contact number ....E-mail 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 e-mail)

Diagnosis/Provisional Diagnosis

Current medication/ Treatment plan (if any)

General Health and any other comments

Thank you – please return this form by e-mail. Please feel free to photocopy for future use.
Stuart Altoft BVetMed CertAVP(Equine Dentistry) GPCert(EP) BAEDT MRCVS