Animal Dentistry and Oral Surgery Specialists, LLC

Dale Kressin DVM, FAVD, Dipl. AVDC

Patient Referral Form

Fax: 920-233-1956 Phone: 888-598-6684 or 920-420-6746

Date_____ E -mail_____

Owner _____Pet _____Phone _____

Species_____Breed_____Age_____Sex: M MN F FS

Items accompanying patient: ____Radiographs ____Records ____Blood work ____Meds ____Other_____

Date of Dental prophylaxis: _____Do you offer dental radiology services?_____

Previous dental work (extractions/oral surgery/other):

Therapeutics initiated:

Tentative Diagnosis:

INSTRUCTIONS FOR THE **Animal Dentistry and Oral Surgery Specialists, LLC**

____ Consultation only
____I wish to have the attending veterinarian E-mail Case Summary _____ E Mail_____
____Requesting diagnosis and treatment

IMPORTANT: In recognition of changes in patient condition, doctor's evaluation, and client wishes; **Animal Dentistry and Oral Surgery Specialists, LLC** reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates. We refer to other specialists. Indicate if you prefer specific 24 hr facilities or specialists.

Referring Doctor_____Hospital_____ E-mail_____

Clinic phone_____Fax_____

Call me if_____