



Circle City Veterinary Specialty & Emergency Hospital

9650 Mayflower Park Drive

Carmel, IN 46032

Phone: ((317) 872-VETS (8387)

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[www.circlecityvets.com](http://www.circlecityvets.com)

***Referral for Veterinary Dentistry or Oral Surgery***

PATIENT:

Name \_\_\_\_\_ Species \_\_\_\_\_

Breed \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

Vaccinations current: Yes \_\_\_ No \_\_\_ Date Given \_\_\_\_\_

Has the patient received the porphyromonas (periodontal disease) vaccine? Yes \_\_\_ No \_\_\_

Is this animal known to be aggressive? Yes \_\_\_ No \_\_\_

CLIENT:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Referring Veterinarian \_\_\_\_\_ Hospital/Clinic Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Does your hospital have dental radiograph capability? Yes \_\_\_ No \_\_\_

Reason for referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History (please include any known systemic disease):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last dental cleaning \_\_\_\_\_

Have any extractions or other oral treatment been performed? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tentative diagnosis \_\_\_\_\_

Patient's overall condition: Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Lab Work: Yes \_\_\_ No \_\_\_ Radiographs: Yes \_\_\_ No \_\_\_

Current therapy

\_\_\_\_\_

Medication	Date	Dose/frequency	Response
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please remember to include complete copies of medical records.**

A summary of each visit will be forwarded to you and your client. Inquiries, comments, and suggestions are always welcome. Thank you. *The Staff of Circle City Veterinary Specialty & Emergency Hospital*