

# WCVM Dental Consultation Form

(Referring Veterinarian to fill out this side of form)

## Referring Veterinarian Information:

\_\_\_\_\_  
Referring Veterinarian

\_\_\_\_\_  
Clinic Name

\_\_\_\_\_  
Clinic Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Province / State

\_\_\_\_\_  
Postal Code / Zip Code

(\_\_\_\_)\_\_\_\_\_  
Phone

(\_\_\_\_)\_\_\_\_\_  
Fax

\_\_\_\_\_  
Date of Submission

## 2. Patient Information:

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Species

\_\_\_\_\_  
Breed

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Age / Date of Birth

## 3. Clinical Summary: *(include history, clinical signs, diagnosis, physical exam and lab findings)*

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

## Please check test material(s) being sent and indicate method of delivery

**4.**  
No. of films: \_\_\_\_\_

**5. Circle Test Performed**  
Flat Radiography  
Other \_\_\_\_\_

**7. Method of Delivery**  
Client Delivered  
Mail  
Courier

Exam date: \_\_\_/\_\_\_/\_\_\_

Exam ID: \_\_\_\_\_  
(Film ID or Pt. ID)

**You will receive an invoice for the WCVM dental consultation fee— Please make cheques payable to:**

## **Interpretation**