



13331 York Center Drive, Suite A
Charlotte, NC 28273

704-588-9788
704-588-9781 (Fax)

FAX TRANSMITTAL FORM



Attention:

From:

Company:

Date Sent:

Phone:

Time Sent:

Fax:

Number of Pages (including coversheet):

Urgent Reply ASAP Please Comment Please Review For your info



Message:

When you fax the dental referral form, please also send the following:

- 1) Vaccine history should include a printout of the vaccine due dates as well as a copy of the actual Rabies certificate.
- 2) Any recent labwork, especially pre-anesthetic panels.
- 3) Any of your notes related to the oral issue.
- 4) Whether your clinic offers the Porphyromonas vaccine.

Have the client then call us to set up the initial dental consultation appointment with Dr. Queck or Dr. Gleason.



13331 York Center Drive, Suite A
Charlotte, NC 28273

704.588.9788
704.588.9781 (Fax)

DENTAL REFERRAL FORM

Date: ___/___/___

CLIENT

Name: _____

Address: _____

City/St/Zip _____, _____

Phone: (____)____-_____

ANIMAL

Name: _____

Species: _____

Breed: _____

Color: _____

Sex: _____

DOB/Age: _____

REFERRAL

DVM: _____ Clinic: _____

Phone: (____)____-_____ Address: _____

FAX: (____)____-_____ City/St/Zip _____, _____

Doctor's e-mail: _____@_____._____

Yes / No Does your clinic offer the porphyromonas vaccine?

***REASON FOR VISIT:**

