Mike Wiegand DVM
Residency Trained, Practice Limited to Dentistry & Oral Surgery
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Dental Radiograph or Case Consultation Form

Date: ___ /___ /___

Referring Veterinarian Information

Referring Doctors Name: ______________________________
Name of Hospital: ______________________________
Hospital Phone Number: ______________________________
Preferred time to call: ______________________________
Hospital email address: ______________________________

Patient Information

Name of Pet: ______________________________
Breed: ______________________________
Sex: ❒ Male ❒ Neutered ❒ Female ❒ Spayed

Species: Canine ❒ Feline ❒
Age/DOB ____________

Relevant case history including clinical symptoms, oral findings and any specific concerns or questions you would like answered:

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History of Dental Problems/Treatments:

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Please submit all dental radiographs and/or case images in JPEG format via our online portal or email.

Consultation requests are reviewed within one business day of submission. **If you have an urgent case, please call the Florida Animal Dentistry & Oral Surgery Center directly at (561) 515-6711.**