Florida Animal Dentistry
& ORAL SURGERY CENTER

Mike Wiegand DVM
Residency Trained, Practice Limited to Dentistry & Oral Surgery
www.FloridaAnimalDentistry.com
Office@FloridaAnimalDentistry.com
Phone & Fax: (561) 515-6711

Dental and Oral Surgery Referral Form

Date: ___ /___ /___

Referring Veterinarian Information

Referring Veterinarian: _____
Referring Animal Hospital: _____
Address (only if first referral): _____
Phone: _____ Fax: _____ Email: _____
How would you like to receive case reports? ❒ **Fax** ❒ **Mail** ❒ **Email**
Please indicate if you would like to also be contacted by phone ❒**Yes** ❒**No**
Please indicate if you would like us to contact this client? ❒**Yes** ❒**No**, please wait for the client to contact you.

Patient Information

Client Name: _____
Client Home Phone: _____ Mobile Phone: _____
Client Email: _____
Name of Pet: _____ Species: Canine ❒ Feline ❒
Breed: _____ Age/DOB _____
Sex: ❒ Male ❒ Neutered ❒ Female ❒ Spayed
Reason for Referral? _____
_____
Please list any relevant medical and dental history: _____
_____
Current medications or supplements: (Doses / Frequencies / Duration) _____
_____
History of Anesthetic related problems / Drug reactions: _____
_____
Additional Information or Comments: _____
_____

To allow your patients visit to run as smoothly as possible please provide any relevant records and diagnostic test results including any lab and/or radiographic findings via our online portal, email (Office@FloridaAnimalDentistry.com) or fax 561-515-6711. Please submit all dental radiographs and/or case images in JPEG format via our online portal or email.

Thank you for the Referral. We strive to provide the best possible care for your patients. Please do not hesitate to contact us if you have any questions regarding this referral.