



# Veterinary Dentistry and Oral Surgery of New Mexico, LLC

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## Dental and Oral Surgery Referral Request

Date of referral \_\_\_\_\_

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

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Species \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Email \_\_\_\_\_

Referring Veterinarian/Hospital \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

Primary Veterinarian/Hospital (if different) \_\_\_\_\_

**Primary problem and reason for referral. Please include any relevant history.** (orthodontic evaluation, fractured tooth, advanced periodontal disease, jaw fracture, cleft palate, oral cancer, etc.)

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Any other comments or concerns \_\_\_\_\_

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### Medical Records (last 2 years)

☐ Attached

☐ E-mailed separately

☐ None

### Bloodwork (last 2 years)

☐ Attached

☐ E-mailed separately

☐ None

### Dental Radiographs

☐ Attached

☐ E-mailed separately

☐ None

### ECG/Echo

☐ Attached

☐ E-mailed separately

☐ None

Total # of pages including this form \_\_\_\_\_

**Please email to [referrals@vetdentistrynm.com](mailto:referrals@vetdentistrynm.com)  
or fax to 800-646-9352. Thank you!!!**

ROOT CANAL THERAPY • PERIODONTAL DISEASE • ORTHODONTICS • RESTORATIONS AND FILLINGS • CROWN THERAPY • ORAL AND DENTAL RADIOLOGY  
CONE BEAM CT IMAGING • JAW FRACTURE REPAIR • PALATAL DEFECT REPAIR • ORAL TUMOR REMOVAL • EXTRACTIONS • ORAL MEDICINE

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