



# Evergreen Veterinary Dentistry Services

735 Goldstream Avenue, Unit 133, Victoria, BC, V9B 2X4  
778 - 601 - 3898 [referrals@evds.ca](mailto:referrals@evds.ca)

## REFERRAL FORM

Referral Date: \_\_\_\_\_

### STATUS:

- Emergency  
 Urgent  
 As Available

### Patient Information

Patient Name:	Species/Breed:	Colour:
Weight (kg):	Age:	DOB: DAY / MONTH / YEAR
Demeanor: <input type="checkbox"/> Friendly <input type="checkbox"/> Shy <input type="checkbox"/> Anxious <input type="checkbox"/> Unpredictable	<input type="checkbox"/> Aggressive <input type="checkbox"/> Bites/Scratches <input type="checkbox"/> Muzzle <input type="checkbox"/> Requires PVP medications	Certified working dog? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No
Breeding or show animal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pet Insurance & Policy #:

### Client Information

Client Last Name:	Client First Name(s):	
Street Address:	City:	Postal Code:
Primary Number:	Other:	Email:

### Referring Clinic Information

Veterinary Hospital:	Phone #:
Veterinarian:	Email:

### REFER TO:

- Any/No Preference  
 Dr. Lana Bissett DVM, DAVDC  
 Dr. Olivia Saunders BVM&S MRCVS, Practice Limited to Veterinary Dentistry and Oral Surgery

**Reason for Referral & Patient History:** *please describe in detail*

Date of last dental procedure/COHAT: \_\_\_\_\_

## MEDICAL HISTORY QUESTIONS:

**Dental Radiographs/Oral Imaging/Photographs** – has either been obtained in the last 2 years?

- Yes
- Date: \_\_\_\_\_ (please send in JPEG format)
- No

*\*For malocclusion assessment, please send photos of:*



**Oral Biopsies** - for oral lesions or masses, have any additional diagnostics been performed?

- Yes
- Date: \_\_\_\_\_
  - Results: \_\_\_\_\_
- No

**Bloodwork** (CBC/Chemistry) - required on pets 6 years and older. Has blood work been obtained and interpreted in the past 6 months?

- Yes
- Date: \_\_\_\_\_
  - Results: \_\_\_\_\_
- No

**Thoracic Radiographs** (3-view) – required on all pets 10 years and older, as well as any pets with a heart murmur, arrhythmia or pulmonary hypertension. Have thoracic x-rays been obtained and interpreted in the past 6 months?

- Yes
- Date: \_\_\_\_\_
  - Doctor interpretation: \_\_\_\_\_
- No

**Cardiac Ultrasound** – echocardiograms are recommended on any patient with heart disease (murmurs, arrhythmias)

Has a cardiac work up been performed?

- Yes
- Date: \_\_\_\_\_
- No

**Has the patient been diagnosed with any of the following?** Please check all that apply.

- Heart Disease       Liver Disease       Seizures       Thyroid Disorder
- Kidney Disease       Respiratory Disease       Diabetes       Allergies

**Has the patient been experiencing any of the following?** Please check all that apply.

- Coughing       Nasal discharge       Diarrhea/soft stool
- Sneezing       Vomiting       Signs of oral discomfort

**Medications** (current or recent):

Drug	Dose	Frequency

**Any known allergies?**

- Yes – please list:
- No

*To facilitate timely triage and scheduling—especially for urgent or emergent cases—we request that all applicable diagnostics be completed prior to referral submission. Please include the last 2 years of medical records. **All pertinent information must be received before we contact your client.** Incomplete submissions will result in delays in scheduling.*

**Please submit this referral form, as well as all pertinent medical records to [referrals@evds.ca](mailto:referrals@evds.ca)**