EQUINE DENTISTRY REFERRAL REQUEST FORM

Coombefield Vets Equine Clinic, Summerleaze Farm, Kilmington, EX13 7RA
Tel: 01297 630515 Fax: 01297 630505
equine@axvets.co.uk

Date.....

Delete as appropriate: Client will contact Coombefield / Coombefield to Contact Client

URGENT CASE? YES/NO ANIMAL INSURED YES/NO
HAVE YOU PREVIOUSLY DISCUSSED THIS CASE WITH THE REFERRAL TEAM? YES/NO
HAS AN ESTIMATE BEEN GIVEN? YES/NO (if yes please specify amount).....

Referring Equine Dental Technician.....
Contact number .....E-mail Address.....

Clients Usual Veterinary Surgeon.....Practice.....
Has the Clients usual Vet been informed of the problem? Yes/No
Has the horse been examined for this problem by a Vet? Yes/No

CLIENT DETAILS

Name.....

Address.....
Contact Numbers (home)..... Mobile.....

PATIENT DETAILS

Name..... Age..... Sex.....
Breed.....

MEDICAL DETAILS

History Leading to Referral

Diagnosis/Provisional Diagnosis

Previous Dental Treatment (please provide copy of chart if appropriate)

Current medication

General Health and any other comments

Thank you – please return this form by post, fax or e-mail. Please feel free to photocopy for future use.

Stuart Altoft BVetMed CertAVP(Equine Dentistry) GPCert(EP) BAEDT MRCVS