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 Veterinary Surgeon.....
Practice (and branch if appropriate).....
Contact number .....E-mail Address.....

CLIENT DETAILS

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

PATIENT DETAILS

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

MEDICAL DETAILS

Previous Dental Treatment

History

Diagnostic Imaging Yes/No (please send digital images by e-mail)

Diagnosis/Provisional Diagnosis

Current medication/ Treatment plan (if any)

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