EVERGREEN VETERINARY DENTISTRY SERVICES REFERRAL FORM

735 Goldstream Avenue, Suite

133 Victoria, BC. V9B 2X4

Phone: (778) 601-3898 Fax: (778) 601-3897

Email: referrals@evds.ca

Today's Date (MM/DD/YY):

STATUS: Emergency ☐ Urgent ☐ As Available ☐

NEW! Our practice is expanding! Please select preference below:

☐ **Dr. Lana Bissett,** DVM, DAVDC *(Board Certified Veterinary Dentist)*

☐ **Dr. Olivia Saunders**, BVM&S MRCVS *(Advanced Practitioner-Practice limited to Dentistry and Oral Surgery)*
Joining our clinic as of January 27th, 2026.

☐ **No Preference**

CLIENT INFORMATION:

Client Name: Mobile Phone Number:

Spouse/Partner/Alternate: Alternate/Spouse

Number: Landline or Other: Email:

Street Address:

City: Province: Postal Code:

PATIENT INFORMATION:

Name: Weight (in kgs):

Date of Birth (MM/DD/YY): Age:

Species: Breed: Colour:

Sex: ☐ M ☐ MN ☐ F ☐ FS

Is this pet insured? ☐ YES ☐ NO Company: Policy:

Is this patient a CAUTION? ☐ YES ☐ NO
BITES ☐ SCRATCHES ☐ UNPREDICATBLE ☐ MUZZLE ☐

Is this patient a Certified Service Dog (sight, mobility, seizure/diabetic detection, PTSD etc.)
or **Working Dog** (police/military/protection)? ☐ YES ☐ NO

If Yes: What function does patient perform?

Is this patient a breeding or show dog/cat? ☐ YES ☐ NO

Reason for Referral and Patient History (Please include client expectation ie. Root Canal, Extraction, etc.):

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

Heart Disease ☐ Liver Disease ☐ Seizure Disorders ☐ Thyroid Disease ☐

Kidney Disease ☐ Respiratory Disease ☐ Diabetes ☐

What Medication(s) is the patient currently on/have been dispensed:

DIAGNOSTICS:

- **Bloodwork** within the last 3 months (we require blood work on pets 6 years and older prior to surgery):

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

  Abnormal Results?

- Have **Chest Radiographs** been obtained?

  (We require rads on pets 10 years and older or with changing heart disease/pulmonary hypertension)

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

- Has an **Ultrasound/Echo** been performed?

  Yes ☐ No ☐ If yes, date (MM/DD/YY):

Date of last COHAT Procedure (MM/DD/YY):

Checklist: Have you included

☐ **Photos** (Masses, dental fractures, level of dental disease, malocclusion, facial trauma etc.)
☐ **Dental Radiographs**
☐ **Biopsy Results** (If this patient is being seen for an oral mass or suspicious lesions)

Please attach **only the last 2 years** of patient medical record **(INCLUDING ALL DIAGNOSTICS)**. We will contact your client to schedule an appointment/procedure once the full medical record has been received.

REFERRING CLINIC:

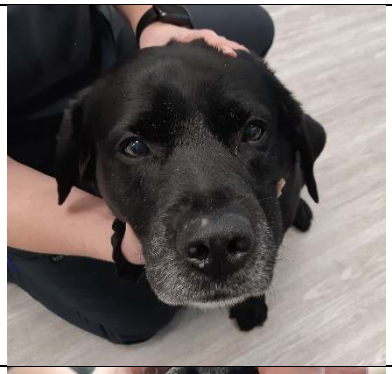
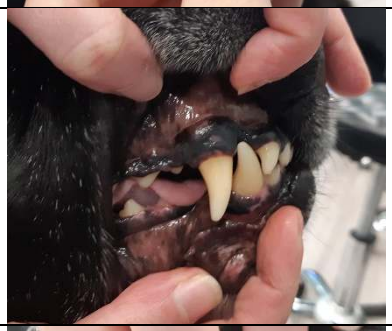
Veterinary Clinic Name:

Veterinarian:

Work #: Email:

Doctor Signature:

For Malocculsion Assessment

Face – face the pet	
Incisors – close the mouth from front, hold the lips	
Right side – close the mouth and hold the lips	
Left side – close the mouth and hold the lips