**Bowmont Animal Hospital**

5111 Bowness Rd NW, Calgary, AB T3B 4M9

www.bowmontanimalhospital.com

Phone: 403-286-2727

Fax: 403-286-2796

**Dental Referral Request Form**

Date Referring Veterinarian (first and last name)

Clinic Name/Address

Phone Fax Email

Preferred Method of Correspondence: Phone ⬜ Fax ⬜ Email ⬜

Owner Name (first and last) Cell Phone

Home Phone Address

City Province Postal Code

Patient Name Species Breed

Sex: Male ⬜ Female ⬜ Altered: Yes ⬜ No ⬜ Date of Birth Color

Reason for referral (please include location, duration, progression, previous dental treatments)

Pertinent medical or surgical history (please attach relevant medical records, lab results and recent blood work)

Other comments

For office use:

AviMark number:

Dr. Mackenzie notified/initial:

Owner contacted:

Left Message:

Appt. Day/Time:

Please choose one of the following options:

I would like Dr. MacKenzie to call me prior to seeing the patient ⬜

Bowmont will contact the owner to set up an appointment ⬜

An appointment has been scheduled for ⬜