**Patient Referral Form**

P: 206-­­204-­­3366

F: 206-­­204-­­3858

**AMCS Department of Dentistry**

|  |  |
| --- | --- |
| **Client & Patient Information** | **Referring Doctor Information** |
| Client Name |  | Primary DVM |  |
| Patient Name |  | Hospital |  |
| Client Phone |  | Address |  |
| Lab Used |  | DVM Phone |  |
| Lab Acct. # |  | DVM Fax |  |
|  |
| **Brief Case History** |
| *Please include all intraoral radiographs, laboratory and other diagnostic reports.*  |
| **Referral Request** |
| As the referring veterinarian my expectations for this case are as follows:***Important note:*** In recognition of changes in patient condition, doctor's evaluation and client wishes, AMCS reserves the right to change diagnostic or therapeutic plans for any patient when good clinical judgment dictates. |



**From I-5 Northbound:**

Take exit **175** toward **WA-523/NE 145th St**

Slight **left** at **5th Ave NE**

Take the 1st **right** onto **NE 145th St/WA-523 E**

Turn **left** at **15th Ave NE**

Destination will be on the right

**From I-5 Southbound:**

Take exit **175** for **WA-523/NE 145th St** toward **5th Ave NE**

Turn **left** at **NE 145th St/WA-523 E** Turn **left** at **15th Ave NE** Destination will be on the right

14810 15th Avenue NE, Suite B, Shoreline, WA 98155