

# Patient Referral Form

P: 206--204--3366

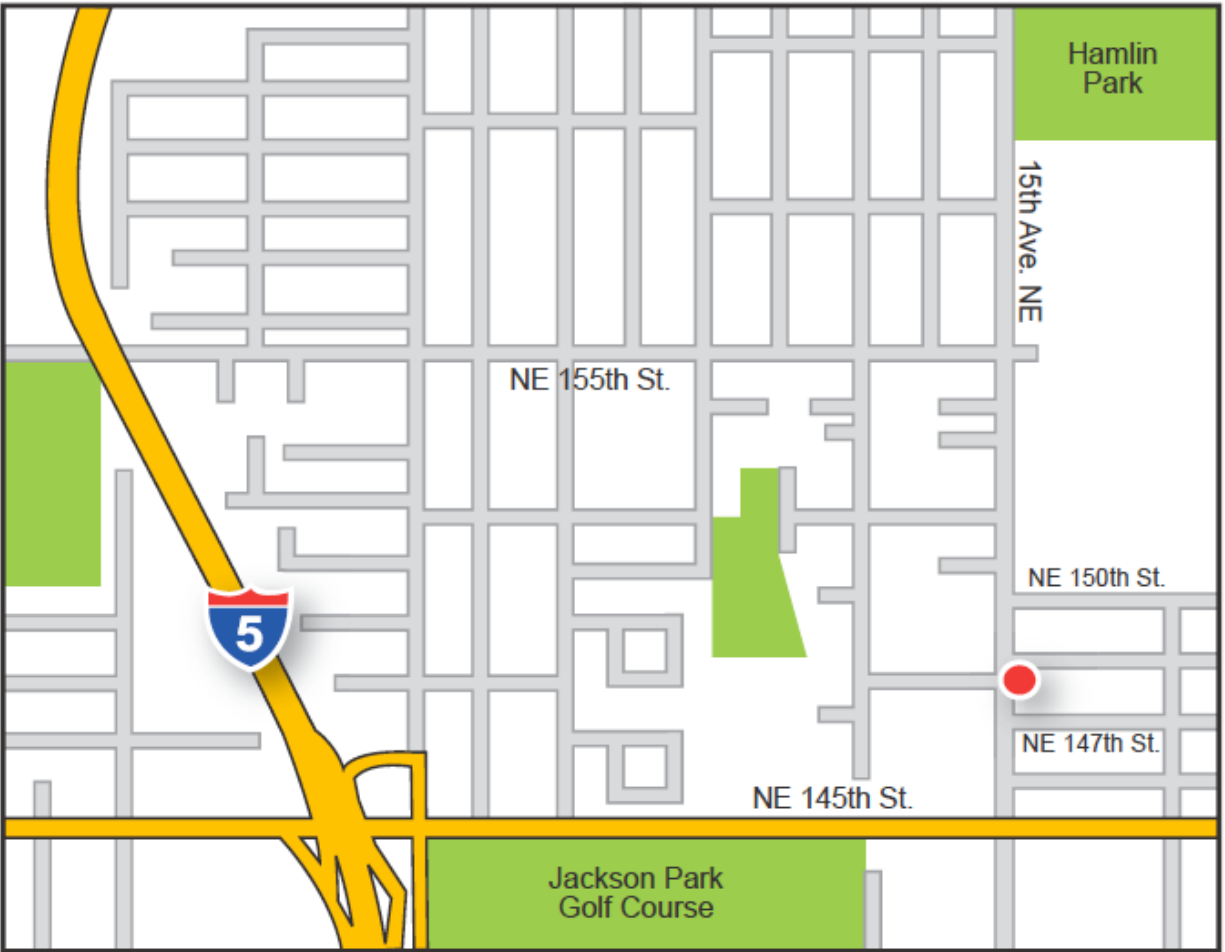
F: 206--204--3858

AMCS Department of Dentistry



**Animal  
Medical Center**  
of Seattle

Client & Patient Information		Referring Doctor Information	
Client Name		Primary DVM	
Patient Name		Hospital	
Client Phone		Address	
Lab Used		DVM Phone	
Lab Acct. #		DVM Fax	
<b>Brief Case History</b>			
<i>Please include all intraoral radiographs, laboratory and other diagnostic reports.</i>			
<b>Referral Request</b>			
As the referring veterinarian my expectations for this case are as follows:			
<b>Important note:</b> 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 15<sup>th</sup> Avenue NE, Suite B, Shoreline, WA 98155