

# 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:			
<i><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.</i>			

**THANK YOU FOR YOUR REFERRAL.**

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