



# Advance Dentistry Referral Form

**Clients** Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Pets** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Breed: \_\_\_\_\_ Color: \_\_\_\_\_  
Canine      Feline      Male      Female      Spayed/Neutered Yes No

## Referring Veterinarian

Veterinarian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Practice Email: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like to speak with Dr. Gleason before the procedure/consult?    Yes    No

Included with Referral: Vaccine History \_\_\_\_\_ Blood Work \_\_\_\_\_ Dental Rads \_\_\_\_\_

Send requested information via fax to 704-274-1570 or email to [info@hambrightvets.com](mailto:info@hambrightvets.com)

***\*Once the Referral is received, we will contact the client to schedule the consultation\*  
Consultation Fee is \$155 (due at the time of scheduling)***

*Please know a referral of your patient to us for dental care is something we appreciate and do not take for granted. Your client and patient will be treated with care and respect. No services other than dentistry will be performed on your patient unless you specifically request that we do so. Please trust that your client and patient will return to you for all non-dentistry services and may not become general practice clients of Hambright Animal Hospital.*