



ANIMAL DENTAL  
CLINIC

15800 SW Upper Boones Ferry Rd.  
Lake Oswego, OR 97035  
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To:<rf-first-name> <rf-last-name> Fax: <rf-faxno>

Please take a few moments to complete our referral form.

Date:\_\_\_\_\_

Patient Name: \_\_\_\_\_ Owner Name: \_\_\_\_\_

Referring Veterinarian: \_\_\_\_\_

Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Pertinent pictures and/or intra-oral radiographs taken  Yes  No If yes please submit radiographs and pictures via email to [animaldentalclinicnw@yahoo.com](mailto:animaldentalclinicnw@yahoo.com)

To best serve the needs of this patient, we'd love to hear your concern related to patient's oral health. Please take a moment to share your clinical summary. Thank you for you referrals.

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**Please submit most recent exam notes and lab work along with referral form via email or fax. Fax 503-445-4509 [animaldentalclinicnw@yahoo.com](mailto:animaldentalclinicnw@yahoo.com)**

Diagnostic procedure options:

- Cone beam CT under general anesthesia ONLY (CT \$600.00 Interpretation \$135.00)
- Cone beam CT with oral charting, and oral evaluation by a veterinary dentist under general anesthesia (CT \$600.00 Interpretation \$135.00 Oral evaluation \$97.00)
- Cone beam CT with oral charting and evaluation, incisional biopsy and/or culture swabs under general anesthesia (Estimate Provided on request)