



Referral Information

Date: _____

Client Name: _____ Phone Number: _____

Patient Name: _____

Species: _____ Breed: _____

Age: _____ Weight: _____ Sex: _____ Color: _____

Referring Clinic Information:

Clinic Name: _____ Phone Number: _____

Veterinarian Name: _____ Fax Number: _____

Primary Care Veterinarian (if different): _____

Clinical Condition/Diagnosis: _____

Onset/Surgery Date: _____

Current Treatment/Medications: _____

Special Instructions/Precautions: _____

Referring Veterinarian Signature: _____

*Completion of this form authorizes evaluation and enrollment in rehabilitative therapy for the patient noted above.

Medical management of this case is to be conducted by the referring and/or primary care veterinarian. Clients seeking medical service(s) other than rehabilitative therapy will be directed to the referring veterinarian, primary care veterinarian or appropriate specialty center.