Canine Rehabilitation Referral Form

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Referring Clinic:____

Referring Veterinarian:__________________________ **Phone:**_________________________

Fax:_____________________ **E-mail:** ____

Are you the patient's primary veterinarian? Y N

Client:__________________________ **Phone:**_________________________________

Address:________________________ **City:**______________________ **Zip:**_______________

Patient:_____________________ **Breed:**_____________________ **Sex:**_______ **Age:**_____

Primary Diagnosis:_____________________________________ **Onset Date:**____________

Surgery Date(s):_________________________ **Surgical Summary Included? Y N**

Additional Medical Conditions: ____

Current Medications: ____

Reason for Referral:

- € **Musculoskeletal/Arthritis**
- € **Post-Operative Rehab**
- € **Neurological**
- € **Weight Management/Conditioning**
- € **Other:**________________________________

Plan:

- € **Evaluate and Treat**
- € **Massage**
- € **Hydrotherapy**
- € **Therapeutic Exercise**
- € **Cold Laser**
- € **Other:**_____________________

Contraindications: ____

Frequency of Rehab: ______________________________________

DVM Signature: ____

Please E-mail or fax this form to northmacombk9rehab@gmail.com or (586)752-1532