(EMAIL TO INFO@PAWREHAB.COM or via fax 818-860-7672)

 **VETERINARY REFERRAL FORM** Date: \_\_\_\_\_\_\_\_\_

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| --- |
| **DVM INFORMATION:**  |
| Referring Doctor:  | Preferred Contact Method:  |
| Hospital Name:  |
| Phone:  | Fax:  | Email:  |
| Address:  |
| City/State:  | Zip Code:  |
| **OWNER’S INFORMATION:**  |  |
| Owner’s Name:  | Phone: |
| Address:  |
| **PATIENT’S INFORMATION:**  |
| Pet’s Name:  | Date of Birth/Age:  |
| Breed:  | Sex:  | Weight: |
| Presenting Problem: |
| History: |
| Diagnostic tests performed (Please include date and results, or if pending, your lab and hospital numbers): |
|  |
| Treatments/Medication (please include dates if possible): |
|  |
| Response to therapy: |
|  |
| Patient being referred for the following services:☐ Physical Rehabilitation Therapy Consult & Treatment☐ Integrative Medicine/Acupuncture/Holistic Consultation (may include: Acupuncture, Herbals, Homeopathy, Supplements, Food/Diet Therapy)☐ Weight Loss & Conditioning Program (Exercise, Diet & Supplements)☐ Senior Rehabilitation & Wellness Program (Exercise for the Mind & Body, Arthritis Management & Supplements or Herbals for Well-Being) |
| Additional comments: |
|   |

Please send radiographs, laboratory tests and a summary of the medical record either by email to info@pawrehab.com or with the

client. Clients may call us to schedule an appointment at 818-847-7299.