(EMAIL TO [INFO@PAWREHAB.COM](mailto:INFO@PAWREHAB.COM?subject=) or via fax 818-860-7672)

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.