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Physical Rehabilitation Referral Form

Client Name: ____ **Date:** _______________

Patient Name: _____________________________ **Species:** ____________ **M/F:** ______

Referring Clinic: ___________________________ **rDVM:** _______________________

Clinic phone #: ___________________________ **Clinic fax #:** ____________________

Reason for referral/History: ____

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Date diagnosed: __________________

Applicable x-rays or tests performed for diagnosis? ☐ **Yes** ☐ **No**
Please list and fax applicable records/tests.

____

Current Pain meds or supplements: ____

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<u>Check therapies of interest:</u>

- ☐ **Physical Rehab Exercises/Therapies**
- ☐ **Underwater Treadmill**
- ☐ **Laser Therapy**
- ☐ **Chiropractic Care**
- ☐ **Acupuncture/Chinese Medicine**

Current or Past Chiropractic or Acupuncture Treatments: _____________________
By whom and when : ____

Any other info. or comments/requests? ______________________________________

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We appreciate your referral!
We will be happy to fax your clinic our evaluation and rehab plan/proposed schedule after the initial consultation. Any non-rehab related problems or questions will be directed to your office, unless otherwise requested. Please have the owner contact our office to set up the consultation appointment. Fax any relevant records to our office at your convenience.