Rehabilitation Referral Information

Referring Veterinarian_____ Practice Name:_____

Phone:_____ Fax:_____Email:_____

Client Name:_____ Client Phone:_____

Client Email:_____

Client Address:_____

Patient Name:_____Age:_____ Sex:_____ Breed:_____

Reason(s) for referral/Goals of rehabilitation:_____

_____

_____

_____

Previous surgery/Treatments (please include dates):

_____

_____

_____

Current medications and dosages:

_____

_____

Brief History of pertinent medical information:_____

_____

_____

List any known restrictions:_____

_____

_____

_____

Completion of this form authorizes Tread Well Canine Rehabilitation to treat the above referred patient with services indicated for rehabilitation. As the referring veterinarian, I understand that I remain the primary care provider.

Veterinarian:_____ **Date:**_____

Contact Info:
rehab@elkrapidsanimalhospital.com
231-264-6700

Pam Graves, DVM, CCRT

Missi Campbell, LVT, CCRP