Rehabilitation Referral Form

Referring Veterinarian Information:

Physician's Name: _____
Facility Name: _____
Mailing Address: _____
_____

Telephone: _____ Fax: _____ Email Address: _____
Preferred method of contact: Phone or Email (please circle)

Client Information:
Client Name: _____ Contact Number: _____
Email Address: _____ Home Address: _____
_____

Patient Information:
Pet Name: _____ Age: _____ Male □ Female □ S/N □
Species: _____ Breed: _____
Current Weight: _____ BCS: _____

Current Medications (including known supplements): _____
_____
_____

History/Chief Complaint: ***Date of onset:*** _____
_____
_____
_____

Previous Health History: _____

Surgical History: _____
_____
_____

Diagnosis: _____
Functional mobility: _____
Lameness Score: _____ ***Pain Score:*** _____

Plan: _____
_____

Date of follow-up visit with rDVM: _____

By making this referral, I am acknowledging that my patient will be assessed and a rehabilitation plan will be recommended by one of the rehabilitation technicians through Wholistic Paws Veterinary Services. I agree to act as the supervising veterinarian in this case and recognize that my patient is not seeing one of the veterinarians on staff at Wholistic Paws.

DVM Signature: _____ ***Date:*** _____