



# Physical Rehab. + Alt. Med.

**Please Include:** Radiographs, copies of laboratory tests and a summary of the medical record. Radiographs will be returned promptly. Referral information may be mailed, sent with the client, or sent via fax. If using the mail please allow enough time for the information to arrive so it is available at the time of the consultation. Phone consults with rDVMs are welcome and encouraged. **Please have your client call to make an appointment.**

## Referral Form

Date:

### rDVM Information

Referring Doctor:	Phone:
Hospital Name:	Fax:
Hospital Address:	Best time to call:
Email Address:	Preferred method of contact:    phone    fax    email

### Patient Information

Owner's Name:	Phone:
Owner's Address:	
Pet's name:	Species:    canine     feline     other
Breed(s):	Birthday (or approx. age):    Weight:
Current on vaccinations?    yes    no	Spayed/Neutered?    yes    no    Sex:    male    female
Presenting Problem:	
Diagnosis:	
Surgical Procedures + Date Performed:	
Treatments/Medications <i>(Please include dosage and dates if possible):</i>	
Is the patient currently receiving chemotherapy or radiation therapy?    yes    no	
Pre-existing Conditions:	
Precautions:	

### Referred For:

- Rehabilitation Services / Evaluation + Treatment**
- Acupuncture Services**
- Holistic Consultation** *(Chinese and Western Herbs, Supplements, Food Therapy)*
- Weight Loss Program** *(Land or Underwater Treadmill, Diet, Supplements)*
- Geriatric Program** *(Alternative therapies for pain, mobility, the immune system and cognitive function)*

I have reviewed and completed this form for submission to Animal Specialty Group for the evaluation of my patient:

\_\_\_\_\_ *Referring Veterinarian Signature*

