

<b>Client:</b>		<b>Address:</b>	
<b>Phone:</b>		<b>Pet:</b>	<b>Breed:</b>
<b>Patient:</b>	<b>Sex:</b>	<b>DOB:</b>	<b>Weight:</b>

<b>Referring Veterinarian:</b>			
<b>Clinic</b>			
<b>Address</b>			
<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Phone</b>	<b>Ext</b>	<b>Fax</b>	
<b>Email/URL</b>			

**Reason for Referral**

**Surgical History**

Prior Surgery	Date

**Medical History**

<b>Vaccines</b>	<b>Rabies:</b>	<b>DHLPP:</b>
<b>Dates</b>	<b>Lyme Test:</b>	<b>Lyme Vaccine:</b>

**Current Medications/Dosage**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Evaluate and Treat        | <b>Requested Services</b>                             | <input type="checkbox"/> Evaluation by DVM/reg. rehab therapist |
| <input type="checkbox"/> Acupuncture               | <input type="checkbox"/> Gait Training                | <input type="checkbox"/> Massage                                |
| <input type="checkbox"/> Hot Pack                  | <input type="checkbox"/> Cryotherapy                  | <input type="checkbox"/> Joint Mobilization                     |
| <input type="checkbox"/> Electrical Stimulation    | <input type="checkbox"/> Therapeutic Exercise         | <input type="checkbox"/> Passive Range of Motion                |
| <input type="checkbox"/> Neuromuscular Reeducation | <input type="checkbox"/> Weight-bearing/weight shifts |   |

DVM Signature

Date