

Canine Rehabilitation Center of WNY referral form for treatment (fax number 716-630-1643)

Date_____

Veterinarian_____

Client name_____

Practice_____

Client telephone number_____

Telephone number_____

Address_____

Fax number (to which progress notes will be sent)

Patient name_____

or practice address

Canine Feline Other _____

Breed_____

Date of birth_____

Are you the patient's primary veterinarian? _____

Vaccination dates:

DHPP_____ Rabies_____ 1 yr 3yr

confirmed or tentative

Primary diagnosis_____

Prognosis offered_____

Concurrent medical condition(s)_____

Current medication(s)/treatment_____

Reason for referral:

Musculoskeletal/arthritis

Fitting/training in use of assistive device
(ie. cart, sling)

Post operative therapy

Neurological

Part of obesity management program

Other_____

Please enclose: copy of medical record laboratory results

radiographs

photographs

Goal of treatment:

Special considerations or precautions:

When is the next scheduled progress examination with the patient's veterinarian? _____

Please send more: referral forms information brochures

* Forms may also be downloaded from our website at www.swimyourdog.com