

Referring DVM

Clinic Name

Clinic Phone No.

Clinic / DVM Email Address

Client First & Last Name

Patient Name

Sex

Client Phone No.

Breed

Date of Birth

Presenting Complaint & Diagnosis (if applicable)

Please be specific and provide as much detail as possible to best inform our practitioners

Other Current / Previous Health Concerns

Please identify anything else that our practitioners should be aware of (cancer, heart disease, respiratory condition, etc.)

Other Notes (if applicable)

By signing this document, you are authorizing the certified practitioners / therapists at Rehab Fur Pet to perform physical rehabilitation with the identified patient.

DVM Signature

Date

Please return a signed copy of this form to info@rehabfuryourpet.com along with any additional information or supporting documents such as patient records/notes, imaging reports, etc. that may be helpful for our practitioners.

The treating practitioner / therapist will provide a preliminary report following the patient's initial consultation and first treatment. Additional follow-up reports will be provided regularly on a monthly basis or immediately upon observation of any significant changes or concerns. Follow-up reports will also be provided upon request within two business days.