PHYSICAL REHABILITATION REFERRAL FORM

OWNER'S NAME:		
ADDRESS:	POSTAL CODE:	
PHONE:	EMAIL:	
PET'S NAME:		
BREED:	SEX: M MN F FS	
AGE:	WEIGHT:	
PRIMARY COMPLAINT:		ONSET:
SURGICAL PROCEDURE		DATE:
OTHER MEDICAL CONDITIONS:		
CURRENT MEDICATIONS/SUPPLEMENTS:		

DIAGNOSTICS PERFORMED TO DATE (PLEASE ENSURE THAT ALL RELEVANT DIAGNOSTICS ARE FORWARDED):

- O RADIOGRAPHS
- O ULTRASOUND
- O CT/MRI
- O BLOODWORK

1735 Queen Street East, Toronto, M4L 6S5
Phone: (416) 693-0993
Web: www.torontovetrehab.com
Email: info@torontovetrehab.com

REASON FOR REFERRAL:

- MUSCULOSKELETAL
- NEUROLOGICAL
- OSTEOARTHRITIS
- POST-OPERATIVE REHABILITATION
- CHRONIC PAIN

CONCERNS OR CONTRAINDICATIONS TO INTEGRATIVE MEDICINE OR REHABILITATION THERAPY:

As the Referring Veterinarian, I understand that I remain the primary care provider. Clients seeking any other services will be redirected to the Referring Veterinarian.

REFERRING VETERINARIAN:	
REFFERING CLINIC:	
PHONE:	EMAIL:
HOW WOULD YOU LIKE TO RECEIVE YOUR PATIENT'S UPDATES (PHONE/EMAIL)?	

PRIOR TO THE APPOINTMENT, PLEASE EMAIL THE REFERRAL FORM WITH RELEVANT RECORDS, IMAGING AND LABORATORY RESULTS TO: info@torontovetrehab.com.

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