3210 West Cary Street, Richmond, VA 23221 804-355-9144
caninerehab@carystreetvet.com

Canine Rehabilitation Referral Form

Client name(s):	**Contact number(s):**	**Patient:**
Date: **Breed:**	**Sex:** **Age:**	**Weight:**

Referring DVM/hospital or clinic: _____
Address: _____
Phone number: _____ Fax number: _____
Regular DVM (if different from referring DVM/hospital or clinic):_____
Phone number: _____ Fax number: _____
Clinical condition: _____ Onset/Sx date: _____

Please provide a copy of relevant and comprehensive medical history, diagnostic imaging (if applicable), and treatment(s) since injury/surgery.

Brief history of present condition/illness:

_____
_____
_____
_____
_____

Vaccine history:
DA2PPL4/DA2PP: Date due _____
BORDETELLA: Date due _____
RABIES: Date due _____

Special instructions/precautions:

_____
_____
_____

Plan:

- ☐ Evaluate and treat
- ☐ Therapeutic ultrasound
- ☐ Electrical stimulation
- ☐ Proprioceptive/balance training
- ☐ Assistive device/brace prescription
- ☐ Other: _____
- ☐ Gait training
  - ☐ Manual therapy
- ☐ Underwater treadmill
  - ☐ Therapeutic exercise

DVM Signature: _____ Date: _____