



Veterinarian Referral Form

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www.coloradopetrehabilitation.com

Please complete the information below and either mail or fax the form to Colorado Pet Rehabilitation.

Referring Veterinarian

Name _____ Clinic _____
Phone _____ Fax _____ Address _____
Email _____

Client

Name _____ Address _____
Phone _____

Patient

Name _____ Age or Date of Birth _____
Breed _____ Color _____ Gender _____ Spayed _____ Neutered _____

Referral Information

Clinical condition _____ Onset/Initial surgery date _____
History and supporting information (please include copies of labwork, radiographs, etc.) _____

Current medications (including nutraceuticals and NSAIDs) _____

Special instructions/precautions _____

Desired Services (circle all that apply)

- | | | |
|---|--|--|
| <input type="radio"/> Rehabilitation assessment | <input type="radio"/> Electrical stimulation | <input type="radio"/> Hydrotherapy |
| <input type="radio"/> Massage | <input type="radio"/> Stretching | <input type="radio"/> Acupuncture |
| <input type="radio"/> Therapeutic exercise | <input type="radio"/> Weight-bearing/weight shifts | <input type="radio"/> Passive range of motion |
| <input type="radio"/> Neuromuscular reeducation | <input type="radio"/> Strengthening/conditioning | <input type="radio"/> Owner education/home program |

Desired Outcome of Treatment (circle all that apply)

- | | | |
|---|--|---|
| <input type="radio"/> Restore range of motion | <input type="radio"/> Improve function | <input type="radio"/> Weight reduction |
| <input type="radio"/> Improve strength/conditioning | <input type="radio"/> Pain management | <input type="radio"/> Owner knowledge/understanding |

DVM signature _____

Date _____