

ANIMAL MEDICAL CLINIC
SHERI FASTENRATH, D.V.M.

Canine Rehabilitation Referral Form
Phone (256) 837-9700
Fax (256) 864-0868

Date _____

Veterinarian _____
Practice _____

Telephone number _____
Fax number _____
Practice Address _____

Client name _____
Client telephone _____
Address _____

Patient name _____
Canine Feline Other _____
Breed _____
Date of birth _____
Vaccination dates:
DHPP _____ **1 yr** **3 yr**
RABIES _____ **1 yr** **3 yr**
Bordetella _____ **6 mo** **1 yr**

Are you the patient's primary physician? _____

Would you like to receive progress reports by fax or by mail? _____

Primary diagnosis _____ confirmed tentative
Prognosis offered _____
Concurrent medical condition(s) _____
Current medication(s)/treatment _____

Reason for referral (please circle all that apply):

Musculoskeletal/arthritis Fitting/training in use of assistance device
Post operative therapy (i.e. cart, sling)
Neurological
Part of obesity management program Other _____

Please enclose: copy of medical records 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