ANIMAL THERAPY CENTER

REFERRAL FORM FOR REHABILITATIVE SERVICES

Date: _____

Client Name: _____ Phone: _____

Pet's Name: _____ Age: _____ Sex: _____

Breed: _____ Date Last Rabies Vaccine Was Given: _____

Referring DVM: _____ Phone: _____

Referring Clinic: _____ Fax: _____

Surgery/Injury Date or Working Diagnosis:

Pertinent or Past History:

Current Medications and/or Supplements:

Preferred method of contact for future correspondence:

☐ Phone: _____ ☐ Fax: _____ ☐ Email: _____

Signature of DVM: _____

Please provide medical records, radiographs, and/or laboratory abnormalities via fax (610.865.4190) or email (info@animaltherapycenter.com)