



Edmonton Veterinary
Rehabilitation Clinic

Patient Referral Form

Please fax to 1-866-832-2603

****Please provide client with radiographs for their initial rehabilitation consultation.****

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|--------------------------------|-------------------------------------|----------------------|-----------------------|
| <u>Client Information:</u> | Name: _____ | Address: _____ | PC: _____ |
| | Home Phone: _____ | Cell Phone: _____ | Other: _____ |
| <u>Patient Information:</u> | Name: _____ | Date of Birth: _____ | Sex: _____ |
| | Breed: _____ | Colour: _____ | Vaccine Status: _____ |
| | | | Weight: _____ |
| <u>Referring Veterinarian:</u> | Clinic Name: _____ | Veterinarian: _____ | |
| | Phone: _____ | Fax: _____ | Email: _____ |
| | Other Veterinarians Involved: _____ | | |

Reason for referral: _____

Medical History (presenting complaint, other conditions, allergies): _____

Diagnostic Results (lab, rads, u/s, etc.): _____

Current Medications/Supplements: _____

Signature of Referring Veterinarian: _____ Date: _____