

Date: _____

PLEASE FAX TO: 585-663-4418



Physical Rehabilitation Referral Form

Susan Lewis, DVM

Pet's Name: _____

Pet's Breed: _____	Age: _____	Sex: [] M/ [] F
Approximate Weight: _____	CANINE [] FELINE []	
Client Information		
Last Name: _____	First Name: _____	
Telephone Number: (____) _____		
Address: _____		
City _____	State _____	Zip _____

Referring DVM /Practice Information			
Referring DVM: _____			
Referring Hospital: _____			
Address: _____	City: _____	State: _____	Zip: _____

Veterinary Diagnosis: _____

Surgical Procedures Performed: _____

Prognosis Offered: _____

Treatment to Date: _____

Medications: _____

The following are enclosed:
<input type="checkbox"/> Radiographs <input type="checkbox"/> Radiographic Report (s) <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Advanced Imaging <input type="checkbox"/> Advanced Imaging Report(s)

<p>Clients MUST provide evidence of current rabies vaccination Rabies vaccination date: _____</p>

THE ABOVE SAID ANIMAL IS BEING REFERRED TO ANIMAL REHABILITATION CENTER of ROCHESTER or VETERINARY SPECIALIASTS of ROCHESTER FOR EVALUATION, CONSULTATION &/OR PHYSICAL REHABILITATION TREATMENT. SAID OWNERS & THEIR PETS WILL NOT BE ACCEPTED AS ROUTINE CLIENTELE OF THE AFOREMENTIONED HOSPITALS
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