DOGS IN MOTION
IN HOME CANINE REHABILITATION & WELLNESS

Patti Triola, PT, CCRT

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REFERRAL FORM

Veterinarian / Surgeon: _____
Facility Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Client's Name: _____
Address: _____
_____
Phone: _____
Alternate Phone: _____

Primary Veterinarian (if different from above): _____
Facility: _____ Phone: _____ Fax: _____

Dog's Name: _____ Breed: _____
Age: _____ Sex: _____ Spayed / Neutered: _____ Onset of condition: _____
Past Medical History: _____

- The date that this canine can safely begin canine rehab: ____ / ____ / ____
- Any restrictions or guidelines you would like followed (including weight bearing and range of motion):
  _____
- Next Veterinarian / Surgeon follow-up appointment: ____ / ____ / ____

Please either complete the section below OR attach referral letter or medical records.

Summary of any tests (x-ray, CT, myelogram, etc.) performed: _____

_____

Summary of pre-op evaluation including diagnosis: _____

_____

Surgical procedure performed, date, prognosis, and post-op medications: _____

_____

Please fax this signed referral to 847-949-8456.

I authorize Dogs in Motion, Canine Rehabilitation & Wellness to evaluate and treat on the above stated client for rehabilitation following any guidelines or restrictions that I have established.

_____ ____ / ____ / ____
Signature Date

Thank you for choosing Dogs in Motion