VIRGINIA Veterinary SPECIALISTS

370 Greenbrier Drive
Charlottesville, Va 22901

P 434-202-2987
F 434-260-3822

Canine Rehabilitation Referral Form

Client Information: (*please assist us by printing*)

Owner's Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Owner's Email: _____

Animal's Name: _____

Species: _____ **Breed:** _____ **Age:** _____

Color: _____ **Sex:** _____ **Weight:** _____

Reason for Referral: _____

Diagnosis/chief complaint: _____

_____

Significant History/Surgical History/ Current Medications: _____

_____

_____

_____

Rehabilitation Goals or Indications: _____

_____

_____

Clinic Name: _____

Clinic Phone Number: _____

Clinic Email: _____

Referring Veterinarian: _____

Completion of this form authorizes Virginia Veterinary Specialist's Rehabilitation Department to evaluate and treat the above referred patient. As the referring veterinarian I understand that I remain the primary care provider. Clients seeking other care will be redirected to the referring veterinarian.