ARLINGTON PARK VETERINARY SERVICES
Rehabilitation
& Fitness Centre

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Rehabilitation Referral Form

Owner's Name:			Phone:
Address:			Postal Code:
Patient's Name:			Date of Birth:
Breed:	❑ Canine ❑ Feline	❑ Male ❑ Female	Spayed or neutered: ❑ YES ❑ NO

REFERRAL INFORMATION

Clinical Condition:	Onset/Initial surgery date:

Pertinent Medical History: ____

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Date of last vaccination: Rabies: d___ / m___ / y ______ DHP: d___ / m___ / y ______ Parvo: d___ / m___ / y ______ FCP: d___ / m___ / y ______

Current medications (Including nutraceuticals and NSAIDs): ____

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Special instructions/precautions: ____

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Desired Services (check all that apply)

- ❑ Rehabilitation assessment
- ❑ Hydrotherapy
- ❑ Therapeutic laser
- ❑ Therapeutic ultrasound
- ❑ Strengthening/conditioning
- ❑ Proprioceptive re-education
- ❑ Massage therapy
- ❑ Therapeutic exercise
- ❑ Pulsed electromagnetic field therapy

Desired Outcome of Treatment (check all that apply)

- ❑ Restore range of motion
- ❑ Improve strength/conditioning
- ❑ Improve function
- ❑ Pain management
- ❑ Weight reduction
- ❑ Owner knowledge/understanding

I certify that the above described patient has had a physical examination within the last three months and has no known health problems that will endanger him / her during physical rehabilitation.

I prefer to receive treatment plans and medical updates by: ❑ Fax ______________________ ❑ Email ____

Veterinarian's Signature: _X_______________________________________ Date: ______________________

Veterinarian's Name: ____ Hospital: ______________________

Thank you for your referral. We develop each patient's treatment plan individually and are committed to achieving the highest quality outcome for your patient. We will provide you treatment plan and regular progress updates. Any conditions arising during your patient's treatment with us will be referred back to you or the regular veterinary clinic for assessment. Please feel free to contact us at any time regarding your patient's rehabilitation and/or conditioning program.