MITCHELL ANIMAL HOSPITAL
CANINE PHYSCIAL REHABILIATION CENTRE

Massage Patient Referral Form

Patient Name:_____ Age:_____Breed:_____
Colour/Markings: _____ Sex(circle):Male/Female/Spayed/Neutered
Vaccine Status:_____

Client Name:_____ Phone: _____
Email Address: _____
Address: _____
City: _____ Prov: _____ Postal Code: _____

Reason for referral: _____
_____
Goals of Massage: _____
Contraindications? If any of the below are present, massage should not be recommended.

- *Skin problems
- *Malignancy
- *Circulatory issues
- *Diabetes
- *Fever or infection
- *Acute trauma
- *Medications that affect circulatory system

Medications: _____
Special Considerations or Precautions: _____
_____

Referring Veterinarian: _____
Referring Clinic: _____
Phone number: _____ Fax Number: _____
Email: _____
**Please enclose/email a copy of any medical records

Signature of referring veterinarian:_____ Date:_____

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