# MITCHELL ANIMAL HOSPITAL
# CANINE PHYSCIAL REHABILIATION CENTRE

## Massage Patient Referral Form

Patient Name:_____ Age:_____ Breed:_____
Sex: Male/Female  Spayed/Neutered (circle one)
Rabies Vaccination Date: _____

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

Reason for referral: _____
_____
Goals of Massage: _____
Any contraindications present? If any, massage should not be recommended.

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

If any of the above, please briefly explain: _____
_____
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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