MITCHELL ANIMAL HOSPITAL
CANINE PHYSICAL REHABILITATION CENTRE

Patient Referral Form

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

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

Reason for Referral: _____
_____
Diagnosis: _____
Prognosis Offered: _____
Goals of Treatment: _____
Concurrent Medical Conditions: _____
_____
Medications: _____
_____
Special Considerations or Precautions: _____
_____

Please enclose/email a copy of any medical records and any relevant radiographs

Referring Veterinarian: _____
Referring Clinic: _____
Phone Number: _____ Fax Number: _____
Email: _____
How would you prefer to be contacted with progress reports:
phone/fax/email (please circle one)

Signature of referring veterinarian: _____ Date: _____

1-408 Gage Ave
Kitchener, ON N2M 5C9
Phone: 519-743-1322 Fax: 519-743-7507
Email: vets@mahonline.com