



**MITCHELL ANIMAL HOSPITAL  
CANINE PHYSICAL REHABILITATION CENTRE**

Patient Referral Form

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Breed: \_\_\_\_\_  
Sex: Male/Female Spayed/Neutered  
Vaccine Status: \_\_\_\_\_

Client Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prognosis Offered: \_\_\_\_\_

Goals of Treatment: \_\_\_\_\_

Concurrent Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_

Special Considerations or Precautions: \_\_\_\_\_  
\_\_\_\_\_

Please enclose/fax a copy of any medical records and lab results

Referring Veterinarian: \_\_\_\_\_

Referring Clinic: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

How would you prefer to be contacted with progress reports:  
phone/fax/email/mail (please circle one).

Signature of referring veterinarian: \_\_\_\_\_ Date: \_\_\_\_\_

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