

Please print this form, fill it out, and bring it with you for your appointment



Shaker Veterinary Hospital, P.C.

223 Maxwell Road, Latham, NY 12110

Phone: (518) 458-9669

Fax: (518) 453-6107

Rehabilitation Referral Form

Referring Clinic _____ Phone _____

DVM _____ FAX _____

Date client last seen by referring DVM _____

Please enclose Copy of medical records Laboratory results

Radiographs by mail Radiographs sent with client

Reason for Referral: Musculoskeletal/Arthritis Post Operative Therapy

Neurological Weight Loss Endurance Training Other _____

Owner Name _____ Home Phone _____

Address _____ Work Phone _____

Animal Name _____ Breed/color _____

Age/DOB _____ Male/Female _____ Neutered/ spayed _____

Vaccination Status _____ Date Rabies updated _____

Diet/supplements _____ Allergies _____

Diagnosis _____

Previous Medical History _____

Injuries/fractures _____

Surgeries/dates _____

History of Present Illness _____

Current Medications/Treatment _____

Diagnostic Testing/results _____

Current clinical condition _____

Precautions/limitations _____

Weight-bearing status _____ Prognosis: Good Fair Poor

Goal of Treatment:

DVM Signature _____ Date _____

Office Use: _____ Date received _____ Client contact date _____